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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02196 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 02179

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME SM 9/60

1. **PLACE OF DEATH**
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Camp Springs
d. STREET ADDRESS: 1 6403 Temple Hills Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Leon — Middle: (Unknown) — Last: Allen

4. **DATE OF DEATH**: Month: February — Day: 27, — Year: 1962

5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: Nov. 18, 1875 — 9. AGE (In years last birthday): 86 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gardner (Ret.)
10b. KIND OF BUSINESS OR INDUSTRY: Truck Gardner
11. BIRTHPLACE (State or foreign country): Prince Geo. Cty., Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Isaiah Allen
14. MOTHER'S MAIDEN NAME: Laura Margaret Pyles

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Zora M. Corley — Address: RFD Box 4424, Upper Marlboro, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 42X Acute congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): Cardiovascular renal disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.
EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED: 2/28/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar. 3-62
22c. NAME OF CEMETERY OR CREMATORY: Bells Methodist Cem.
22d. LOCATION (City, town, or country): Camp Springs (State): Md

23. FUNERAL DIRECTOR: Simmons Bros
ADDRESS: 1661- Good Hope Rd SE Wash 20 D.C.
24a. REC'D BY REGISTRAR DATE: MAR 2 '62
24b. REGISTRAR'S SIGNATURE: Arthur L. Evans

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02197 **CERTIFICATE OF DEATH** 02180

1. PLACE OF DEATH
a. COUNTY: Prince George's — STATE: MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 63 Hyattsville
d. STREET ADDRESS: 4618 Burlington Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Richardson — Last: Ashbrook

4. DATE OF DEATH: Month: February — Day: 20 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-30-84

9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Edward Richardson

14. MOTHER'S MAIDEN NAME: Mary Schackmann

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): no

16. SOCIAL SECURITY NO.: 579-44-1536B

17. INFORMANT — Address: Grover H. Ashbrook Same as #2 (Husband)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 420.1 Myocardial Infarction, Anterior — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Coronary artery thrombosis — 3 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): " " atherosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2-17, 1962 to 2-20, 1962 that (I) (we) last saw the deceased alive on 2-20 1962 and that death occured at 8:40 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Donald C. Ebgren M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2-20-62

22c. PHYSICIAN'S NAME (Type): DONALD C. EBGREN

22d. ADDRESS: HYATTSVILLE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Entombment

23b. DATE THEREOF: 2/23/62

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill

23d. LOCATION (City, town or county) (State): Suitland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Francis Gasch's Sons Hyattsville, Maryland

25a. REC'D BY REGISTRAR DATE: FEB 23 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Mans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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Coroner notified and approved B.K.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

02198

CERTIFICATE OF DEATH

02181

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Suitland 23
c. LENGTH OF STAY IN 1b: 5 to 7 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suitland Nursing Home, Inc.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D. C.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (1609- 30th St. S.E Washington
d. STREET ADDRESS: Washington DC 41X3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MALVINA — Middle — Last BACHE

4. DATE OF DEATH: Month February — Day 6 — Year 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 5/17/77
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laboratory Worker
10b. KIND OF BUSINESS OR INDUSTRY: Hospital
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U. S. America

13. FATHER'S NAME: William Russell
14. MOTHER'S MAIDEN NAME: Margaret Watts Burton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 5-5450-6662
17. INFORMANT: Mrs Nora Seidler (daughter) Address: as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO (b): Hypertension Arteriosclerosis — unknown
DUE TO (c): Arteriosclerosis — unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4 4 3 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19
20d. INJURY OCCURRED White at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 1 19 62 to Feb 6 19 62 that (I) (we) last saw the deceased alive on Feb 3 19 62, and that death occurred at 05 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Henry G. Hadley M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Feb. 6 1962
22c. PHYSICIAN'S NAME (Type): Henry G. Hadley
22d. ADDRESS: 4601--Nichols Ave S.W. Wash. DC

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Feb. 7-62
23c. NAME OF CEMETERY OR CREMATORY: Inglewood Cemetery
23d. LOCATION (City, town, or county) (State): Inglewood - Calif.

24. FUNERAL DIRECTOR'S SIGNATURE: Simmons Bros.
ADDRESS: 1661- Good Hope Rd SE Wash 20 DC
25a. REC'D BY REGISTRAR DATE FEB 8 '62
25b. REGISTRAR'S SIGNATURE: Clarence E. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
ISM 9/59

Items 16&20 Film 311 4-[illegible]-62 ms

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02199 Items 2 & 14 Film G307 2/26/62 lwk 02182

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANDREWS AIR FORCE BASE
c. LENGTH OF STAY IN 1b: 4 HRS 25 MIN
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: US AIR FORCE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND Penna
b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANDREWS AIR FORCE BASE Pittsburg 75X3
d. STREET ADDRESS: 1406 N. Homewood Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO XX

3. NAME OF DECEASED (Type or print): First JAMES; Middle; Last BANNER
4. DATE OF DEATH: Month FEBRUARY; Day 21; Year 1962
5. SEX: MALE
6. COLOR OR RACE: NEGRO
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10 JUNE 1931
9. AGE (In years last birthday): 30 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): AIRMAN
10b. KIND OF BUSINESS OR INDUSTRY: US AIR FORCE
11. BIRTHPLACE (State or foreign country): PITTSBURGH, PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? UNITED STATES
13. FATHER'S NAME: OLIVER BANNER
14. MOTHER'S MAIDEN NAME: LUCILLE unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): 1952 -PRESENT
16. SOCIAL SECURITY NO.: 194-22-4744
17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiovascular Collapse
DUE TO (b): Fatty necrosis of heart, kidneys, liver
DUE TO (c): Phosphorus poisoning
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 971.6
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Suicide due to depressive reaction.
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): SUICIDE Ingestion of commercial preparation of rat poison.
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m.: Unk. 20-21Feb 62
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Barracks
20f. (City or town) AAFB, (County) -Pr. Geo. (State) Wash. 25 D.C.

21. I certify that (I) (~~this hospital~~) attended the deceased from 21 FEBRUARY 1962, to 21 FEBRUARY 1962, that (I) (~~saw~~) last saw the deceased alive on 21 FEBRUARY 62, and that death occurred at 610A M., from the causes and on the date stated above.

22a. SIGNATURE: William K Grove Capt USAF MC M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 21 FEB 62
22c. PHYSICIAN'S NAME (Type): WILLIAM K GROVE, Capt USAF MC
22d. ADDRESS: USAF Hospital, Andrews Air Force Base, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 23 FEB 62
23c. NAME OF CEMETERY OR CREMATORY:
23d. LOCATION (City, town, or county) (State): PITTSBURGH PENNA.

24. FUNERAL DIRECTOR'S SIGNATURE: B. F. Taylor
ADDRESS: 909 6th St, N.W. D.C.
25a. REC'D BY REGISTRAR DATE: FEB 23 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02200 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 02183

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bowie
d. STREET ADDRESS: Fletcherstown Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ernest; Middle: Martin; Last: Barrios

4. DATE OF DEATH: Month: February; Day: 9th; Year: 1962

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 12/85

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Florida

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Emanuel Barrios

14. MOTHER'S MAIDEN NAME: Elizabeth Carter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes give war or dates of service): WWI

16. SOCIAL SECURITY NO.: 203-22-8488

17. INFORMANT: Mrs Carrie Fletcher, Address: same as #7

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Cardiovascular renal disease
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 2/9/62

EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 2.13.62
22c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NAT'L. CEM.
22d. LOCATION (City, town, or country) (State): ARLINGTON, VIRGINIA

23. FUNERAL DIRECTOR: Robert F. Weaver
ADDRESS: 1829 9TH ST., WASHINGTON, D.C.
24a. REC'D BY REGISTRAR: N. W. DATE FEB 13 '62
24b. REGISTRAR'S SIGNATURE: Curtis L. Evans

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02201 (Reg. Dist. No.) 02184

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Landover Hills
c. LENGTH OF STAY IN 1b: 1½ yr.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): #109 Beall Street

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Maryland
b. COUNTY: St. Marys
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First BLANCHE Middle IRENE Last BENNETT

4. DATE OF DEATH: Month 2 Day 6 Year 1962

5. SEX: FEMALE

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: MARCH 26, 1880

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Leonardtown, Md

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Bushrod Nash

14. MOTHER'S MAIDEN NAME: Maria Elizabeth Dyer

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO: none

17. INFORMANT: R. M. Bennett — Address: 6003 Hilmett Rd Forestville Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Carcinoma of Bladder — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs.

DUE TO (b): —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/15, 1961, to 2/6, 1962, that I last saw the deceased alive on 2/4/, 1962, and that death occurred at 6:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: F E Musser M.D — ADDRESS (Street, city or town, state): 4410 74th ave — DATE SIGNED: 2/6/62

PHYSICIAN'S NAME (Type): F. E. Musser — Landover Hills Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-9-1962

22c. NAME OF CEMETERY OR CREMATORY: Mt Olivet

22d. LOCATION (City, town, or county) (State): Wash D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A Mattingly — ADDRESS: 131-11th St S E

24a. REC'D BY REGISTRAR DATE: FEB 9 '62

24b. REGISTRAR'S SIGNATURE: C. [illegible] Brown

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02202 02185

1. PLACE OF DEATH
a. COUNTY: Prince Georges County MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): 74 Beltsville
d. STREET ADDRESS: 4615 Powder Mill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LOUIS Middle HENRY Last BIELIGK

4. DATE OF DEATH: Month February Day 4, Year 1962.

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 31,1902

9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Printer

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): District of Columbia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Henry Bieligk

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 579-28-7509

17. INFORMANT: Girlie Sammie Bieligk, Same as # 2 Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 420.1 Coronary occlussion — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Coronary artery disease
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.

Address (Street, city, town, or county):

DATE SIGNED: February 5, 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb. 8/62

22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery

22d. LOCATION (City, town, or country) (State): Bladensburg Maryland

23. FUNERAL DIRECTOR ADDRESS: W. W. Chambers Co., Riverdale, Md.

24a. REC'D BY REGISTRAR DATE: B 8 '62

24b. REGISTRAR'S SIGNATURE: C[illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 9,60

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02203 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02186

1. PLACE OF DEATH
a. COUNTY: Prince George's — b. STATE: MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Camp Springs — c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Andrews Air Force Base Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lanham
d. STREET ADDRESS: 9447 Washington Boulevard
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Carl — Middle: Herman — Last: Blush
4. DATE OF DEATH: Month: February — Day: 24, — Year: 1962

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 19, 1910
9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): District of Columbia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edwin Blush
14. MOTHER'S MAIDEN NAME: Gertrude McDonald

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 579-01-3164
17. INFORMANT: Anna Marie Blush, same as # 2 — Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 4 (illegible) — DUE TO: MYOCARDIAL INFARCTION
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO: SEVERE CORONARY ATHEROSCLEROSIS
(c)
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ASPIRATION OF VOMITUS
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day — Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.
EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 2/25/62

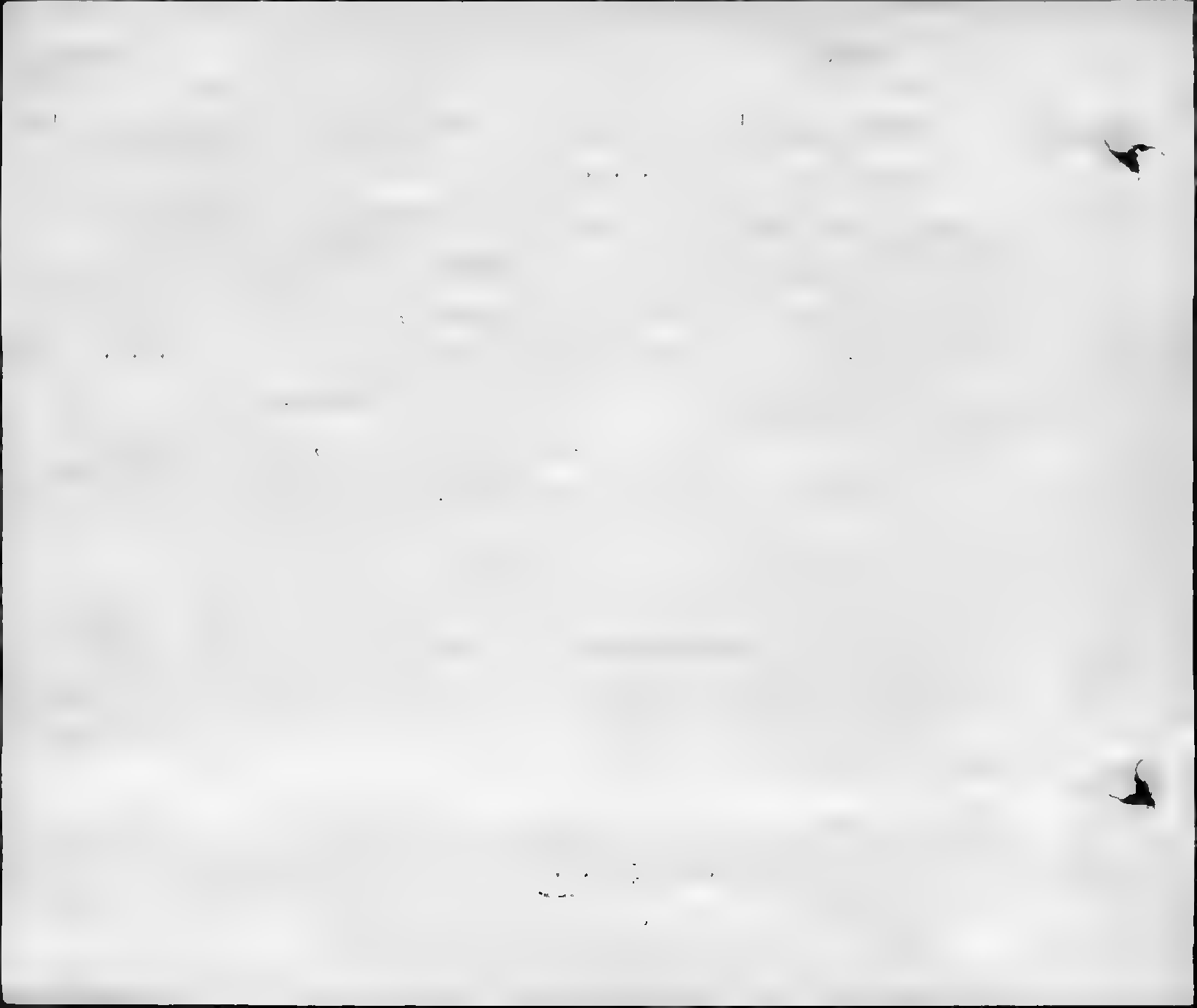
22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-28-1962
22c. NAME OF CEMETERY OR CREMATORY: Washington National
22d. LOCATION (City, town, or country) (State): Suitland, Maryland

23. FUNERAL DIRECTOR: W.W. Chambers Co — ADDRESS: Riverdale, Md.

24a. REC'D BY REGISTRAR DATE: MAR 1 '62
24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISMP
5M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02204

CERTIFICATE OF DEATH

02187

1

M

1. PLACE OF DEATH
a. COUNTY: Prince Georges
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN MARYLAND: 5 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If not institutional Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X 5115 Flintwood Drive
d. STREET ADDRESS: Hyattsville., ~~Md~~ Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby; Middle: Boy "A"; Last: Booher

4. DATE OF DEATH: Month: Feb; Day: 7; Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2 Feb 1962

9. AGE (In years last birthday) yrs. IF UNDER 1 YEAR: Months 5 Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Franklyn Oscar Booher

14. MOTHER'S MAIDEN NAME: Mary Wayne Broucher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mother; Address: Same

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ~~Prematurity~~ Premature Birth (2#3oz)

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2-2, 19 62 to 2-7, 19 62, that (I) (we) last saw the deceased alive on 2-7 19 62, and that death occured at 4:35 AM, from the causes and on the date stated above.

22a. SIGNATURE: A. J. Modlin M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Dr. Albert J. Modlin

22d. ADDRESS: 388 Montrose Avenue, Laurel, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 2-17-62

23c. NAME OF CEMETERY OR CREMATORY: Prince Geo. Gen. Hospital

23d. LOCATION (City, town or county) (State): Cheverly, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Harry W. Penn, Jr., Administrator

ADDRESS

25a. REC'D BY REGISTRAR DATE FEB 20 '62

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Item 15, Film 407

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02205 — 02188

1 PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 5115 Flintwood Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Boy "B" — Last: Booher

4. DATE OF DEATH: Month: Feb — Day: 5 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 2 Feb 1962

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months — Days: 3 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Frank Oscar Booher

14. MOTHER'S MAIDEN NAME: Mary Wayne Broucher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Same Mother — Address: Same as above

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 761.5 — DUE TO: Prematurity

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (b): — DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture humerus due to Injury at birth

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.):

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2-2, 1962 to 2-5, 1962 that (I) (we) last saw the deceased alive on 2-5 1962, and that death occured at 5,20AM from the causes and on the date stated above.

22a. SIGNATURE: Dr. Albert J. Modlin M.D.

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): A. J. Modlin

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22d ADDRESS: 388 Montrose Avenue, Laurel, Md.

23a. BURIAL CREMATION, REMOVAL (Specify): Cremation

23b DATE THEREOF: 2-17-62

23c. NAME OF CEMETERY OR CREMATORY: Prince George Hospital

23d. LOCATION (City, town or county) (State): Cheverly, Md.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Harold L. Penn Jr., Administrator

25a RECD BY REGISTRAR DATE: FEB 26 62

25b REGISTRAR'S SIGNATURE: Clara B. Frame

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02206

CERTIFICATE OF DEATH

Reg. Dist No. 02189

1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville
c LENGTH OF STAY IN 1b 15 yrs
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION 5408-15th Ave.

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE Maryland b COUNTY Prince Georges
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Maryland
d STREET ADDRESS 5408-15th Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First William Middle H. Last Bosley

4. DATE OF DEATH Month Feb. Day 10 Year 1962

5 SEX Male | 6 COLOR OR RACE White | 7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 8. DATE OF BIRTH 11/14, 1868 | 9. AGE (In years last birthday) 93 yrs | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Gilder, Refinishing picture frames | 10b. KIND OF BUSINESS OR INDUSTRY etc | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | 12 CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME William H. Bosley | 14 MOTHER'S MAIDEN NAME Ann Foos

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16 SOCIAL SECURITY NO none | INFORMANT Charles A. Bosley Son Address above

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myo Cardial Failure 5 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Coronary Insufficiency 5 yrs
DUE TO (c) Cardio Vascular Renal Disease 10 yrs

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 | 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State)

21 I certify that I attended the deceased from Feb 5, 19 62 to Feb 10, 19 62 that I last saw the deceased alive on Feb 10, 19 62 and that death occurred at 5:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Robert R. Hottel M.D. ADDRESS (Street, city or town, state) 12211 Monroe St Wash 12 D.C. DATE SIGNED

PHYSICIAN'S NAME (Type) Robert R Hottel Wash 12 D.C.

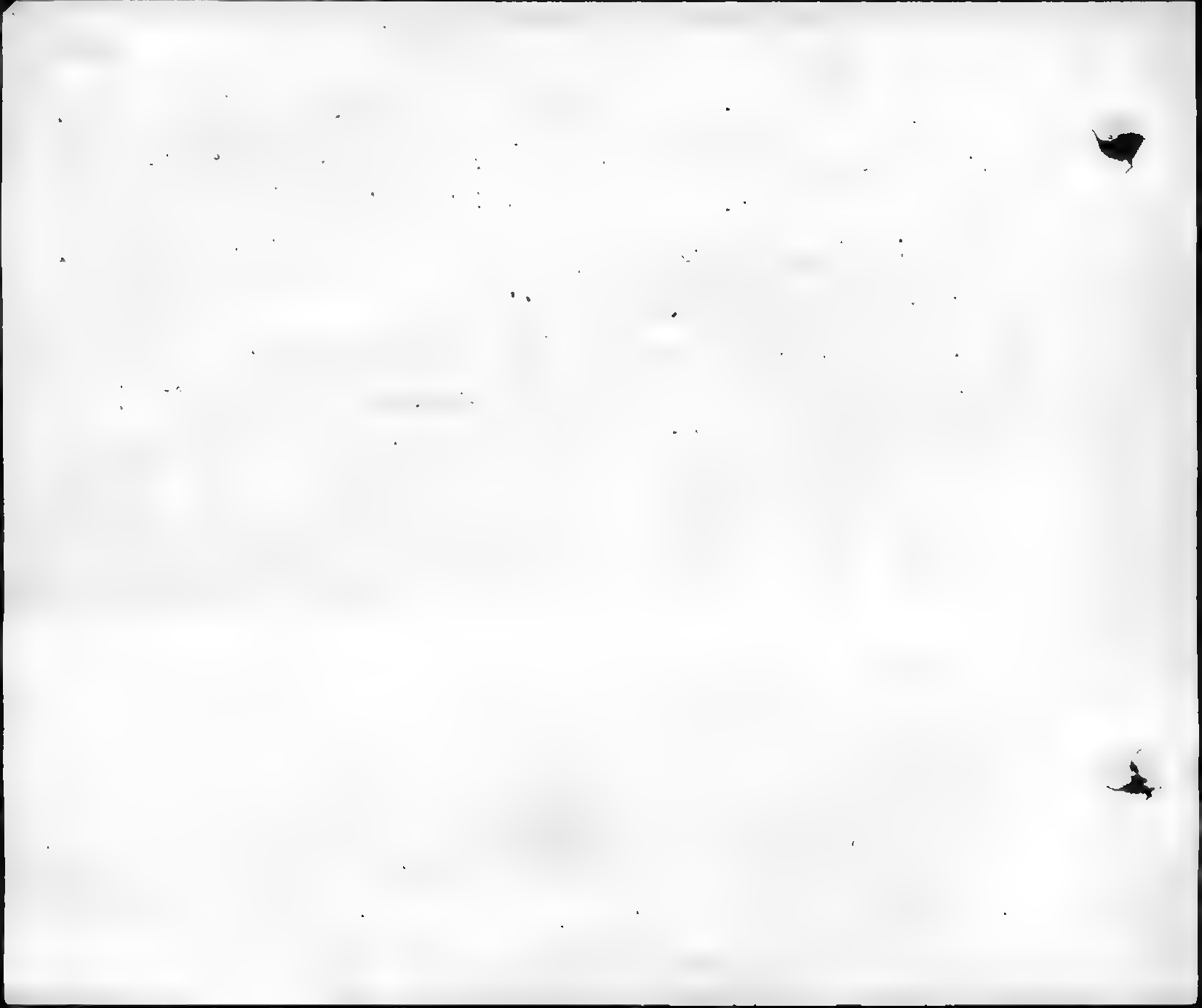
22a BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 2/13/62 | 22c NAME OF CEMETERY OR CREMATORY Cedar Hill | 22d LOCATION (City town, or county) (State) Suitland Md.

23. FUNERAL DIRECTOR'S SIGNATURE Malloy's Funeral Home ADDRESS Mt Rainier Md. | 24a. REC'D BY REGISTRAR DATE FEB 14 '62 | 24b. REGISTRAR'S SIGNATURE

Jone

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02207

CERTIFICATE OF DEATH

02190

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S 43
15M 7 61

1 **PLACE OF DEATH**
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenn Dale (rural)
c. LENGTH OF STAY IN 1b: 2 months and 14 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Glenn Dale Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: D. C. — b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 835 46th St., N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 **NAME OF DECEASED** (Type or print): First: Emanuel — Middle: - — Last: Botts

4 **DATE OF DEATH**: Month: 2 — Day: 20 — Year: 19 62

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 5/6/1888
9 AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min. —

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Porter
10b. KIND OF BUSINESS OR INDUSTRY: Woodward & Lothrop District Bldg.,
11. BIRTHPLACE (County & State, or foreign country): Mo.
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Fred Botts
14. MOTHER'S MAIDEN NAME: Lenora Frakes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16 SOCIAL SECURITY NO.: 577-01-3961
17. INFORMANT: Decedent — Address: —

18 **CAUSE OF DEATH** [Enter only one cause per line for a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a): Pulmonary tuberculosis, moderately advanced; cerebrovascular accident, probably thrombosis with left hemiparesis; encephalomalacia due to cerebral arteriosclerosis; decubiti buttocks and feet

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from 12/6/61 to 2/20/62, that (I) (we) last saw the deceased alive on 2/20/62, and that death occured at 1:45 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Moe Weiss
M.D. ATTENDING PHYS ☐ MED DIRECTOR ☒ STAFF PHYS. ☐
22b. DATE SIGNED: 2/20/62
22c PHYSICIAN'S NAME (Type): Moe Weiss, M.D.
22d. ADDRESS: Glenn Dale Hospital, Glenn Dale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: 2.23.62
23c. NAME OF CEMETERY OR CREMATORY: LINCOLN MEM. CEM.
23d. LOCATION (City, town or county) (State): SUITLAND, MARYLAND

24 FUNERAL DIRECTOR'S SIGNATURE: Robert L McGuire
ADDRESS: 1820 9th St. N.W. WASHINGTON, D.C.
25a. REC'D BY REGISTRAR DATE: FEB 23 '62
25b. REGISTRAR'S SIGNATURE: Clifton L. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02208

CERTIFICATE OF DEATH

02191

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CLINTON
c. LENGTH OF STAY IN 1b: 8 HOURS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SOUTHERN MARYLAND HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LA PLATA
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: WALTER — Middle: C. — Last: BRANNEN

4. DATE OF DEATH: Month: FEB — Day: 5 — Year: 1962

5. SEX: M — 6. COLOR OR RACE: W — 7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: February 11, 1902 — 9. AGE (In years last birthday): 59 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): STORE KEEPER — 10b. KIND OF BUSINESS OR INDUSTRY: RETAIL STORE — 11. BIRTHPLACE (County & State, or foreign country): Georgia — 12. CITIZEN OF WHAT COUNTRY? UNITED STATES

13. FATHER'S NAME: Benton A. Brannen — 14. MOTHER'S MAIDEN NAME: Eliza Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No — 16. SOCIAL SECURITY NO: 401-09-5171 — 17. INFORMANT: (Wife) Mrs. Mary T. Brannen — Address: Box 256 La Plata, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
(a) IMMEDIATE CAUSE: CORONARY occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
(b) arteriosclerosis — 10 years
DUE TO
(c) diabetes mellitus — 15 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2-5 19 62 to 2-5 19 62, that (I) (we) last saw the deceased alive on 2-5 19 62, and that death occured at 3:25 PM, from the causes and on the date stated above.

22a. SIGNATURE: F. M. Johnson M.D — 22b. DATE SIGNED: 2-5-62
22c. PHYSICIAN'S NAME (Type): F. M. JOHNSON M.D
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22d. ADDRESS: LA PLATA Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial — 23b. DATE THEREOF: 2/9/62 — 23c. NAME OF CEMETERY OR CREMATORY: Trinity Memorial Gardens — 23d. LOCATION (City, town or county) (State): Waldorf, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Lucas Funeral Home, Inc. — ADDRESS: La Plata, Md.

25a. REC'D BY REGISTRAR DATE: FEB 9 '62 — 25b. REGISTRAR'S SIGNATURE: Clifton L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02209 02192

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
d. STREET ADDRESS: 5409 Powhatan Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Chancellor; Middle: Long; Last: Brawner
4. DATE OF DEATH: Month: February; Day: 21; Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: August 21, 1870
9. AGE (In years last birthday): 91 yrs.
IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Confectionery
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: UNKNOWN Brawner
14. MOTHER'S MAIDEN NAME: Emmit Merchant

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 214-12-7020
17. INFORMANT: Chancellor Alfred Brawner
Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary embolism
DUE TO (b): Fractured left hip
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell in living room of home
20c. TIME OF INJURY: Hour: 4:00 p.m. Month, Day, Year: 2/20/62
20d. INJURY OCCURRED: While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town): Riverdale P.G. (County): (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER: James I. Boyd M.D.
EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 2/22/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb 26, 1962
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
22d. LOCATION (City, town, or country): (State): Suitland, Maryland

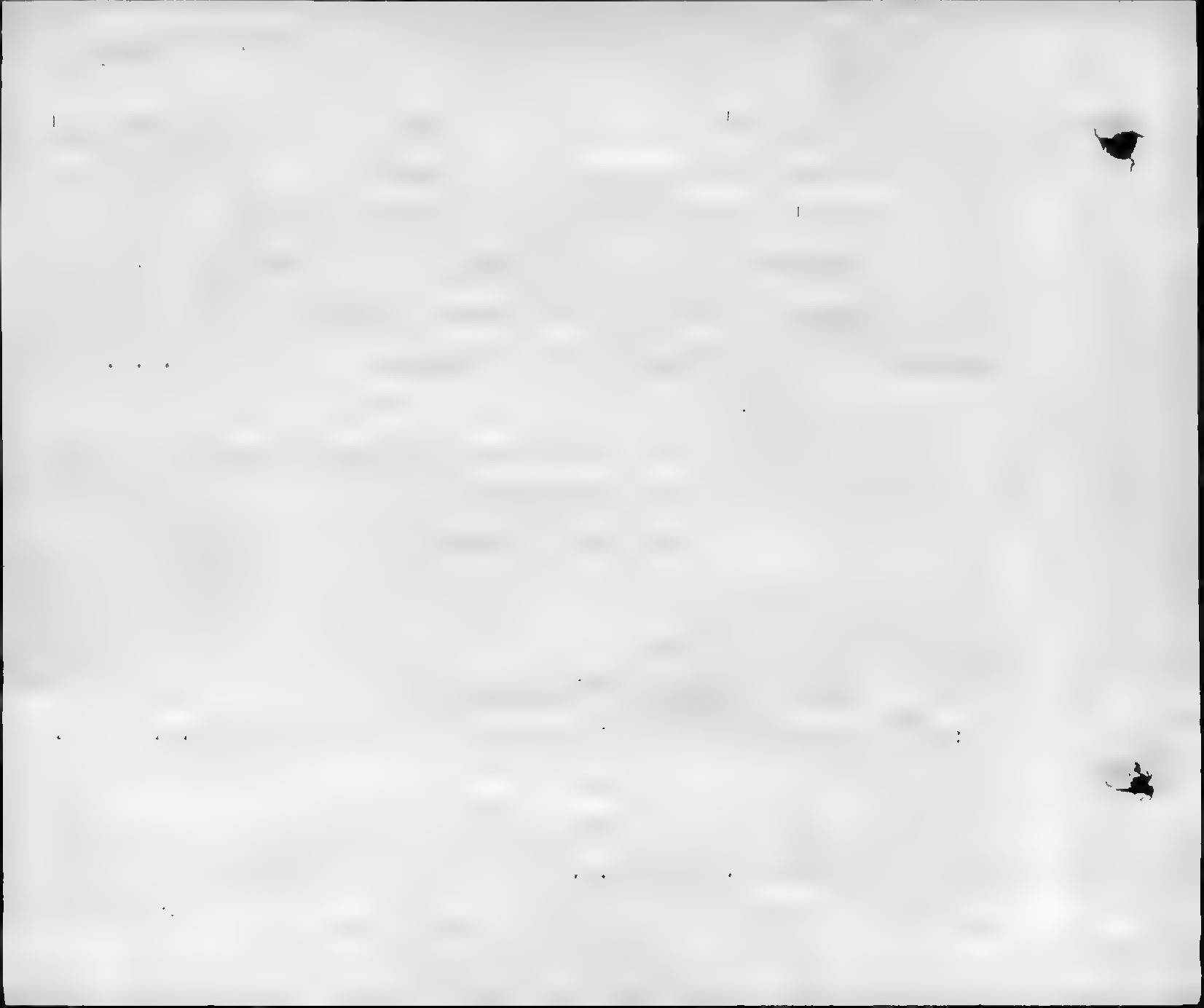
23. FUNERAL DIRECTOR: W.W. Chambers Co.
ADDRESS: Riverdale, Md.

24a. REC'D BY REGISTRAR DATE: FEB 26 '62
24b. REGISTRAR'S SIGNATURE:

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 9 60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02210

CERTIFICATE OF DEATH

02193

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

1. PLACE OF DEATH

a. COUNTY: PRINCE GEORGE'S — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING, MD

c. LENGTH OF STAY IN 1b: 22 YEARS

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 9001 NEW HAMPSHIRE AVE. MISS. SERVANTS MOST HOLY TRINITY

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE: MARYLAND

b. COUNTY: PRINCE GEORGE

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING

d. STREET ADDRESS: 9001 NEW HAMPSHIRE AVE

e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: LAWRENCE — Middle: THOMAS — Last: BREDIGER

4. DATE OF DEATH: Month: FEB. — Day: 9 — Year: 1962

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JUNE 16, 1911

9. AGE (In years last birthday): 50 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CATHOLIC PRIEST.

10b. KIND OF BUSINESS OR INDUSTRY: RELIGIOUS

11. BIRTHPLACE (County & State or foreign country): NEW JERSEY

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: FREDERICK BREDIGER

14. MOTHER'S MAIDEN NAME: KATHRINE A KILKENNY ~~ARATA~~ (MARIE MAIDEN NAME)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or data of service): No

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: FATHER STEPHEN QUINN

Address: MOST HOLY TRINITY MISS. SERVANTS

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: 15 MIN

DUE TO (b): CORONARY ATHEROSCLEROSIS — 5 YEARS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): HYPERTENSIVE CARDIOVASCULAR DISEASE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from FEB. 4, 1953 to FEB. 9, 1962, that (I) (we) last saw the deceased alive on FEB. 9 1962, and that death occured at 9:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE: James A. Roberts M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: FEB. 9, 1962

22c. PHYSICIAN'S NAME (Type): JAMES A ROBERTS M.D.

22d. ADDRESS: 8907 GEORGIA AVE. SILVER SPRING, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2-14-62

23c. NAME OF CEMETERY OR CREMATORY: Holy Trinity Cemetery

23d. LOCATION (City, town or county): Holy Trinity (State): Alabama

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zeka — ADDRESS: 34 Georgia Ave.

Warner E. Pumphrey, Inc. Silver Spring, Md.

25a. REC'D BY REGISTRAR — DATE: FEB 14 '62

25b. REGISTRAR'S SIGNATURE: Edwin L. Timms

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02211 — Item 9 Firm G306 — 2/8/62 iwk — 02194

CERTIFICATE OF DEATH

1. PLACE OF DEATH — a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMP SPRINGS
c. LENGTH OF STAY IN 1b: 4 WEEKS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 6321 BRANCH AVE. S.E.

2. USUAL RESIDENCE (Where deceased lived, If inst tut on Res dence before adm ssion) — a. STATE: VIRGINIA — b. COUNTY: GREENE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): STANDARDSVILLE
d. STREET ADDRESS: RT 1 Box 206
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: EMMA — Middle: FRANCIS — Last: BRILL
4. DATE OF DEATH: Month: FEB. — Day: 2 — Year: 1962

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: SEPT. 22 1886
9. AGE (In years last birthday): 75 Yrs.
IF UNDER 1 YEAR — Months: — Days: — IF UNDER 24 HRS. — Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: FARM
11. BIRTHPLACE (County & State, or foreign country): GREENBRIAR CO. W. VA.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: WILLIAM O'DONOVAN
14. MOTHER'S MAIDEN NAME: Mary Carpenter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: (DTR.) RAMONA MYERS — Address: 6321 BRANCH AVE, S.E.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for a), (b) and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): CEREBROVASCULAR ACCIDENT (HEMORRHAGE)
DUE TO (b): ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE
DUE TO (c):
Conditions, if any, which gave rise to immediate cause a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 1½ HRS. / 15+ YRS.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): NONE

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT, HOMICIDE OR SUICIDE? (IF OTHER, NON-MEDICAL EXAMINER): NONE
20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of Item 18.]: NONE (NOTE, CERTIFICATE SIGNED WITH PERMISSION OF JAS. BOYD M.D.)
20c. TIME OF INJURY — Hour: — A.M. — P.M. — Month, Day, Year: NONE 19
20d. INJURY OCCURRED — While at work [ ] Not while at work [ ]: NONE
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): NONE
20f. (City or town) (County) (State): NONE.

21. I certify that (I) (~~this hospital~~) attended the deceased from JAN. 1961, to PRESENT, that (I) (~~no~~) last saw the deceased alive on FEB. 2 1962 and that death occured at 12:30 AM from the causes and on the date stated above.

22a. SIGNATURE: Arthur Shaver Jr. M.D.
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: FEB 2, 1962
22c. PHYSICIAN'S NAME (Type): ARTHUR SHAVER JR. M.D.
22d. ADDRESS: BRANCH AVE, CLINTON, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2-4-62
23c. NAME OF CEMETERY OR CREMATORY: Standardsville Cem't
23d. LOCATION (City, town or county) (State): Standardsville Va

24. FUNERAL DIRECTOR'S SIGNATURE: Hart Close Funeral Home
ADDRESS: Ruckersville Va
25a. REC'D BY REGISTRAR — DATE: FEB 5 '62
25b. REGISTRAR'S SIGNATURE: Clinton S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
1SM 9/

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02212

CERTIFICATE OF DEATH

02195

1 PLACE OF DEATH
a. COUNTY: PRINCE GEORGE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LAUREL
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Md
b. COUNTY: PRINCE GEORGE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LAUREL
d. STREET ADDRESS: 1514 - 9th St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: ROY Middle: ROBERT Last: BROOKS
4. DATE OF DEATH: Month: FEB Day: 2 Year: 1962
5. SEX: MALE
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JUNE 28 1903
9. AGE (In years last birthday): 58 yrs. IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS. Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): GENERAL LABORER
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State or foreign country): HOWARD Co Md
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: EDWARD BROOKS
14. MOTHER'S MAIDEN NAME: CATHERINE GIBSON
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 705-12-3328
17. INFORMANT: GERTRUDE MATTHEWS
Address: 502 - 9th St LAUREL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): C. A. RT Carotid
DUE TO (b): I.H.D.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 9 Mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town, [County] (State)

21. I certify that (I) (this hospital) attended the deceased from 2/1/62, 1962, to 2/2/62, 1962 that (I) (we) last saw the deceased alive on 2/2/62, 1962 and that death occured at 4 A.M. from the causes and on the date stated above

22a. SIGNATURE: K. P. Warren M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): Bryan P. Warren
22d. ADDRESS: Laurel

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/5/62
23c. NAME OF CEMETERY OR CREMATORY: Bacons
23d. LOCATION (City, town or county): Anne Arundel Co (State): Md

24. FUNERAL DIRECTOR'S SIGNATURE: Ridgely Kelly
ADDRESS: 502-4th St Laurel

25a. REC'D BY REG. STRAR DATE: FEB 5 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02196

CERTIFICATE OF DEATH

02213 Item 12 Film G510 4/2/62 jwk

1. PLACE OF DEATH
a. COUNTY: Prince Georges
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 12 hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Upper Marlboro
d. STREET ADDRESS: Box 3805
IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Baby	Girl	Brown	Feb	6	1962

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min
Female	Black		6 Feb 1962	yrs.		12

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Maryland	U.S.A.

13. FATHER'S NAME: Herman Bernard James Duckett
14. MOTHER'S MAIDEN NAME: Pauline Brown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mother Address: Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	771X	
DUE TO (b)		
DUE TO (c)	Prematurity	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that (I) (this hospital) attended the deceased from 2-6 1962, to 2-6- 1962, that (I) (we) last saw the deceased alive on 2-6- 1962, and that death occured at 10.55PM from the causes and on the date stated above.

22a. SIGNATURE: A. J. Modlin M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Dr. Albert J. Modlin
22d. ADDRESS: 388 Montrose Avenue, Laurel, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county)	(State)
Cremation	2-17-62	Prince George's General Hosp.	Cheverly, Md.	

24. FUNERAL DIRECTOR'S SIGNATURE: Harry J. Penn Jr., Administrator
ADDRESS:

25a. REC'D BY REGISTRAR DATE FEB 20 '62
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 14
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02214 — 02197

CERTIFICATE OF DEATH

Items 11, 12 & 14 Film 3267 2/21/62 iwk

1 PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Mitchellsville
d. STREET ADDRESS: Rt. 1 Box 26
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Debbrah — Middle: P — Last: Brown

4. DATE OF DEATH: Month: Feb — Day: 12 — Year: 19 62

5. SEX: Female

6. COLOR OR RACE: Black

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 26 June 1951

9. AGE (In years last birthday): 10 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James L Brown

14. MOTHER'S MAIDEN NAME: Irene Hamilton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia, Circ. Collapse

550.1 DUE TO (b): Perforated Appendicitis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8 Feb 19 62 to 12 Feb 19 62, that (I) (we) last saw the deceased alive on 12 Feb 19 62, and that death occured at 4:45 PM from the causes and on the date stated above

22a. SIGNATURE: Wm. P. Holbrook M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Dr. William A. Holbrook, Jr.

22d. ADDRESS: 4500 College Avenue, College Park, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 2-15-62

23c. NAME OF CEMETERY OR CREMATORY: Holy Family Church Cem.

23d. LOCATION (City, town or county) (State): Mitchellville, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Mollie R. Gallen ADDRESS: Mollie's Funeral Home 4339 Hunt Rd. 4E

25a. REC'D BY REGISTRAR: DATE FEB 16 '62

25b. REGISTRAR'S SIGNATURE: Clifton S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02215

CERTIFICATE OF DEATH

02198

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN this MARYLAND: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Rainier
d. STREET ADDRESS: 3837 34th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Milton; Middle: ; Last: Bunch
4. DATE OF DEATH: Month: February; Day: 15; Year: 1962

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 8-1-1872
9. AGE (In years last birthday): 89 yrs. IF UNDER 1 YEAR: Months: ; Days: IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Unknown
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Unknown
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Hospital Records
Address: Same as #1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): F-3 C-9 Generalized Arteriosclerosis
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: Unk

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2-12-62, 19..... to 2-15-62, 19....., that (I) (we) last saw the deceased alive on 2-15-62, 19....., and that death occured at 3:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: R B Sasscer M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑
22b. DATE SIGNED
22c. PHYS. CAN'S NAME (Type): Dr. Robert B. G. Sasscer
22d. ADDRESS: R.F.D. Box 2150, Upper Marlboro, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/22/62
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln
23d. LOCATION (City, town or county): Colmar Manor, (State): Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Francis Gasch's Sons
ADDRESS: Hyattsville, Maryland
25a. REC'D BY REGISTRAR DATE: FEB 23 '62
25b REGISTRAR'S SIGNATURE: Conrad L. Timms

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02216

CERTIFICATE OF DEATH

02139

Item 9 Film G207 2/26/62 lwlc

1 PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 7 hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cedar Heights
d. STREET ADDRESS: 1011 62nd Pl.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Mary — Middle: E — Last: Burley

4. DATE OF DEATH: Month: Feb. — Day: 13 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: Black

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 16 May 1905

9 AGE (In years last birthday): 56 58 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b KIND OF BUSINESS OR INDUSTRY: Private Home

11 BIRTHPLACE (County & State, or foreign country): Anne Arundel Co.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Smith

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16 SOCIAL SECURITY NO.

17 INFORMANT: Augusta Hansbury — Address: Same as 2 D

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
(a) IMMEDIATE CAUSE: Cyanotic cardiac infarct
DUE TO
(b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerotic HTD
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12 Feb ....., 1962, to 13 Feb ., 1962., that (I) (we) last saw the deceased alive on 13 Feb 1962 ., and that death occured at 2.30A from the causes and on the date stated above.

22a SIGNATURE: R B Sasscer

22b. DATE SIGNED

M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22c. PHYSICIAN'S NAME (Type): Dr, Robert B Sasscer., M.D.

22d. ADDRESS: R.F.D. Box 2150 Upper Marlboro., Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): 2-17-62

23b DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY: Masica Cem.

23d. LOCATION (City, town or county): Drury (State): Md.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: H S Washington & Son 4925 Deane Ave NE

25a. REC'D BY REGISTRAR DATE: FEB 19 '62

25b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02217

CERTIFICATE OF DEATH

02260

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Prince Georges — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenn Dale (rural)
   c. LENGTH OF STAY IN this place: 5 months and 28 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Glenn Dale Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: D. C. — b. COUNTY: —
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
   d. STREET ADDRESS: 644 Eye St., S.E.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Alexander — Middle: — Last: Burnside

4. **DATE OF DEATH**: Month: 2 — Day: 8 — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4/3/1884

9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months: — Days: — — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired laborer

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (County & State, or foreign country): S.C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joe Burnside

14. MOTHER'S MAIDEN NAME: Eloise ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) Unknown (If yes give war or dates of service) —

16. SOCIAL SECURITY NO.: 579-18-4736

17. INFORMANT: Decedent — Address

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Pulmonary embolus — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO (b): Phlebothrombosis of femoral and iliac vessels — Unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary tuberculosis; diabetes mellitus; generalized arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8/11/61 to 2/8/62, that (I) (we) last saw the deceased alive on 2/8/62, and that death occured at 12:48 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Moe Weiss — M D

22b. DATE SIGNED: 2/8/62

22c. PHYSICIAN'S NAME (Type): Moe Weiss, M. D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22d. ADDRESS: Glenn Dale Hospital, Glenn Dale, Md.

23a. BURIAL CREATION REMOVAL (Specify): Burial — 23b. DATE THEREOF: 2/9/62 — 23c. NAME OF CEMETERY OR ~~CREMATORY~~: Lincoln Memorial — 23d. LOCATION (City, town or county) Suitland (State) Md

24. FUNERAL DIRECTOR'S SIGNATURE: W. William Spangler — ADDRESS: Spangler Fun Home 524-8 & NE D.C.

25a. REC'D BY REGISTRAR DATE FEB 13 '62 — 25b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02218 **CERTIFICATE OF DEATH** 02201

Items 1 & 9 Film G207 2/23/62 iwk

1. **PLACE OF DEATH**
a. COUNTY: Prince Geo hsh. Cheverly MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly Md.
c. LENGTH OF STAY IN this hospital: 30 days
d. NAME OF HOSPITAL OR INSTITUTION (If not hospital, give street address): Prince George's Gen. Hosp.

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Pr. Geo
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Kent Village
d. STREET ADDRESS: 7214 Forest Road.
IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Jack Middle: Carn Last:

4. **DATE OF DEATH**: Month: Feb Day: 13 Year: 1962

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-10-01

9. AGE (In years last birthday): 60 11/12 yrs
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State or foreign country): Durham N. C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: Louis Atwell Address: 7212 Forest Rd. Hyattsville, Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b): Arteriosclerotic Coronary Artery Disease — Unk
DUE TO (c): Intra mural thrombi.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchopneumonia Lobar.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18):

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1-24, 1962 to 2-13, 1962 that (I) (we) last saw the deceased alive on 2-13 1962 and that death occured at 10 A.M. from the causes and on the date stated above.

22a. SIGNATURE: [signature]

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): M D

ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☒

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: FEB 16, 1962

23c. NAME OF CEMETERY OR CREMATORY: Woodfield Cem.

23d. LOCATION (City, town or county): Galesville, (State) Md

24 FUNERAL DIRECTOR'S SIGNATURE: T A Hardesty & Son

ADDRESS: Galesville Md

25a. REC'D BY REGISTRAR DATE: FEB 19 '62

25b. REGISTRAR'S SIGNATURE: [signature] for 8 Hours

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02219

CERTIFICATE OF DEATH

Reg Dist No. 02202

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Meadows
c. LENGTH OF STAY IN 1b: 24 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Old Marlboro Pike

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: P. G.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Meadows
d. STREET ADDRESS: Old Marlboro Pike
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James Middle: Joseph Last: Carroll

4. DATE OF DEATH: Month: Feb Day: 4 Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Mar 27, 1895

9. AGE (In years last birthday): 66 yrs

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Retired Construction

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Carroll

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 577 [illegible]

INFORMANT: Elizabeth C Mulliken Address: 28 Milan Wash 25, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b): Cardiovascular renal disease

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4-42 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a.m. p.m. Month: Day: Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19__ to Feb 4, 1962 that I last saw the deceased alive on Feb 3, 1962, and that death occurred at 5 20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James J. Boyd M.D. ADDRESS (Street, city or town, state): 8200 Marlboro Pike DATE SIGNED:

PHYSICIAN'S NAME (Type): James J. Boyd Washington 25, D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial 22b. DATE THEREOF: 2/7/62

22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l Cem.

22d. LOCATION (City, town, or county) (State): Ft. Myer, Va.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Ritchie Bros. Fun'l Home-Upper Marlboro, Md.

24a. REC'D BY REGISTRAR DATE: FEB 14 '62

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. [illegible] may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02220 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02203

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 9/60

1. PLACE OF DEATH
   a. COUNTY: Prince George's — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Carmody Hills
   c. LENGTH OF STAY IN 1b: 15 years
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 302 73rd. Street

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Prince George's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Carmody Hills
   d. STREET ADDRESS: 302 73rd Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Herbert — Middle: Collier — Last: Coale

4. DATE OF DEATH: Month: February — Day: 2, — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: Nov. 21, 1908

9. AGE (In years last birthday): 53 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Insurance Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Insurance

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Ralph Coale

14. MOTHER'S MAIDEN NAME: Lillian Shepherd

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO: 577-03-7005

17. INFORMANT: Thelma Louise Coale, Address: 3330 31st Street NE Washington D.C.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Hemorrhage and shock — DUE TO

(b): Gun shot wound of the head — DUE TO

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Shot self in the head, while in his home

20c. DATE OF INJURY Month, Day, Year: Found 12:20 p.m. 2/2/ 1962

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Carmody Hills P.G. Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James D. Boyd M.D.

EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

DATE SIGNED: 2/2/62

22a. BURIAL, ~~CREMATION~~, ~~REMOVAL (Specify)~~: burial

22b. DATE THEREOF: 2/6/62

22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery

22d. LOCATION (City, town, or country) (State): Pr.Geo.Co., Maryland

23. FUNERAL DIRECTOR: The S.H.Hines Co., ADDRESS 2901 14th St. N.W. Wash,D.C.

24a. REC'D BY REGISTRAR DATE: FEB 6 '62

24b. REGISTRAR'S SIGNATURE: S. H. Hines & Co.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02221

CERTIFICATE OF DEATH

02204

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenn Dale (rural)
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Glenn Dale Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: D. C.
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: Little Sisters of the Poor
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Leo — Middle: — Last: Corriden

4. DATE OF DEATH: Month: 2 — Day: 20 — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 2/12/01

9. AGE (In years last birthday): 61 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Unknown

16. SOCIAL SECURITY NO: Unknown

17. INFORMANT: Decedent — Address: —

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive gastrointestional hemorrhage, etiology undetermined
DUE TO (b): —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): —

INTERVAL BETWEEN ONSET AND DEATH: 1 day

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebrovascular accident with right hemiparalysis; bronchopneumonia; chronic alcoholism; coardial infarction, historical; auricular fibrillation.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. City or town — (County) — (State)

21. I certify that (I) (this hospital) attended the deceased from 2/16/ 19 62 to 2/20/ 19 62, that (I) (we) last saw the deceased alive on 2/20/ 19 62, and that death occured at 10:38 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Moe Weiss

M.D — ATTENDING PHYS. ☐ — MED. DIRECTOR ☒ — STAFF PHYS. ☐

22b. DATE SIGNED: 2/20/62

22c. PHYSICIAN'S NAME (Type): Moe Weiss, M. D.

22d. ADDRESS: Glenn Dale Hospital, Glenn Dale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb. 23rd/62

23c. NAME OF CEMETERY OR CREMATORY: Mt. Lubentt Cemetery

23d. LOCATION (City, town or county) (State): Mt. Rainier, D. C.

24. FUNERAL DIRECTOR'S SIGNATURE: T. F. Costello

ADDRESS: 1722 N Capitol with N.Y.

25a. REC'D BY REGISTRAR — DATE: FEB 23 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02222

CERTIFICATE OF DEATH

02205

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 13 hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Coral Hills
d. STREET ADDRESS: 5330 Q St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Margaret — Middle: V — Last: Cunico

4. DATE OF DEATH: Month: Feb — Day: 20 — Year: 19 62

5. SEX: Female — 6. COLOR OR RACE: White — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 2 Oct. 1900 — 9. AGE (In years last birthday): 61 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife — 10b. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (County & State, or foreign country): Starkville, Colorado — 12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Dominick Boccaccio — 14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT: John Cunico-husband as above — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Reticulum Cell Sarcoma — INTERVAL BETWEEN ONSET AND DEATH: 2 years

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER.) — 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1-12-, 1962 to 2-20-, 1962, that (I) (we) last saw the deceased alive on 2-19-, 1962 and that death occured at 1,30AM, from the causes and on the date stated above.

22e. SIGNATURE: Peter Duus — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 2-20-62

22c. PHYSICIAN'S NAME (Type): Dr. Peter Duus, M.D. — 22d. ADDRESS: 6124 Central Avenue, Capitol Heights, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 2/23/62 — 23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven — 23d. LOCATION (City, town or county) (State): Greenbelt, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Lee Funeral Home — ADDRESS: Washington D.C

25a. REC'D BY REGISTRAR DATE: FEB 22 '62 — 25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02223 02206

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution - Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Edmonston
d. STREET ADDRESS: 5121 Decatur
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Virginia; Middle: Barcus; Last: Dalzell

4. DATE OF DEATH: Month: February; Day: 2; Year: 19 62

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 27, 1916

9. AGE (In years last birthday): 45 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ~~XXXXX~~ Barcus

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO

17. INFORMANT: Howard Depue Dalzell — Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): LOBAR PNEUMONIA
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): SEVERE FATTY LIVER Alcoholism

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): James I. Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 2/2/62

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 2-3-1962

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or country): Manassas (State): Virginia

23. FUNERAL DIRECTOR: Baker & Son Funeral Home ADDRESS: Manassas, Virginia

24a. REC'D BY REGISTRAR DATE FEB 6 '62

24b. REGISTRAR'S SIGNATURE: Clarence L. Kinnis

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 9 60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02224 — 02207

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): District Height
c. LENGTH OF STAY: N 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 7815 Gateway Boulevard

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George's
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): District Heights
d. STREET ADDRESS: 7815 Gateway Boulevard
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Claire — Middle: Elizabeth — Last: de Lorimier

4. DATE OF DEATH: Month: February — Day: 10, — Year: 19 62

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: December 24, 1889

9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Van Gilder

14. MOTHER'S MAIDEN NAME: Elizabeth Rohrbach

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Frank Berford Evans — Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute congestive heart failure

DUE TO (b): Cardiovascular renal disease

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1 4 2 X

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 2/10/62

EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-13-1962

22c. NAME OF CEMETERY OR CREMATORY: Washington National

22d. LOCATION (City, town, or country) (State): Suitland, Maryland

23. FUNERAL DIRECTOR — ADDRESS: W. W. Chambers Co. Riverdale, Md.

24a. REC'D BY REGISTRAR: FEB 13 '62

24b. REGISTRAR'S SIGNATURE: Carlton L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02225 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02208

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 24 Hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges Gen. Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Upper Marlboro
d. STREET ADDRESS: Box 341 Star Route
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First ALICE Middle LOUISE Last DIGGS

4. DATE OF DEATH: Month Feb. Day 2, Year 1962

5. SEX: Fem.

6. COLOR OR RACE: Colored

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: May 15, 1896

9. AGE (In years last birthday): 66 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Richard Brown

14. MOTHER'S MAIDEN NAME: Jane Forbes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address Mittchellville, Md — Mrs. Margret Blake Route #2 Box 114

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

MEDICAL CERTIFICATION

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): 420.1 Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Coronary heart disease

DUE TO (c): Cardiovascular renal disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes of long duration

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy [ ] Inspection [X] Inquiry [X], and in my opinion death resulted from: Natural causes [X] Accident [ ] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): James I. Boyd

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

DATE SIGNED: 2/3/62

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 2-7-62

22c. NAME OF CEMETERY OR CREMATORY: MT. CARMEL

22d. LOCATION (City, town, or country) (State): UPPER MARLBORO, MD.

23. FUNERAL DIRECTOR: MYRTLE K. ROLLINS — ADDRESS: WASH., D.C. 4339 HUNT PL. N.E.

24a. REC'D BY REGISTRAR — DATE: FEB 5 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

VS. AISME SM 9'60

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02226 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 02209

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 70 College Park
d. STREET ADDRESS: 8707 50th., Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Olin; Middle: Andrew; Last: Dovel
4. DATE OF DEATH: Month: February; Day: 12; Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 6, 1897
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Marine Insurance Ex.
10b. KIND OF BUSINESS OR INDUSTRY: Maritime Commission
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Washington Dovel
14. MOTHER'S MAIDEN NAME: Cora Virginia Snyder

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes; WW 1
16. SOCIAL SECURITY NO.: 577-26-9212
17. INFORMANT: Address: Mary Dovel, same as # 2

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 44XX — Acute congestive heart failure
DUE TO (b): Cardiovascular renal disease
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.
EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED: 2/12/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/12/62
22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln
22d. LOCATION (City, town, or country): Colmar Manor, (State): Md.

23. FUNERAL DIRECTOR: Francis Gasch's Sons
ADDRESS: Hyattsville, Maryland
24a. REC'D BY REGISTRAR DATE: FEB 13 '62
24b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02227 — 02210

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN this MARYLAND place: 15 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Seabrook
d. STREET ADDRESS: 9603 Franklin Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Melba; Middle: B.; Last: Duncan

4. DATE OF DEATH: Month: February; Day: 13; Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1-24-1907

9. AGE (In years last birthday): 55 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: College Instructor

11. BIRTHPLACE (County & State, or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: J Ed Blake

14. MOTHER'S MAIDEN NAME: Cora Burgess

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.

17. INFORMANT: Hospital Records — Address: Cheverly, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Cerebral Thrombosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Uremia
DUE TO (c): Renal Insufficiency

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pyelonephritis and Hypertension

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. / p.m.; Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/29 19 62 to 2/13 19 62 that (I) (we) last saw the deceased alive on 2/13 19 62, and that death occured at 12:38 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Louis B. Bachrach M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Feb 13-1962

22c. PHYSICIAN'S NAME (Type): Dr. Louis B. Bachrach

22d. ADDRESS: 915 19th St., N.W., Washington 6, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb 17, 1962

23c. NAME OF CEMETERY OR CREMATORY: High Lawn Memorial Park

23d. LOCATION (City, town or county) (State): Oak Hill West Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: F. Gasch's Sons

ADDRESS: Hyattsville, Md.

25a. REC'D BY REGISTRAR DATE: FEB 15 '62

25b. REGISTRAR'S SIGNATURE

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02228 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 02211

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9.60

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: MARYLAND D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Landover Hills
d. STREET ADDRESS: 7108 Allison Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William Middle: Albert Last: Elliott
4. DATE OF DEATH: Month: February Day: 25 Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 8, 1914
9. AGE (In years last birthday): 48 yrs. IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS. Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Appliance
11. BIRTHPLACE (State or foreign country): Indiana
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William David Elliott
14. MOTHER'S MAIDEN NAME: Ann Elizabeth Talmadge
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wars or dates of service): no
16. SOCIAL SECURITY NO: 578-05-4851
17. INFORMANT: Ruth Elliott, same as # 2 Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 443X — Acute congestive heart failure
DUE TO (b): Hypertensive heart disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) County (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.
EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town or county):
DATE SIGNED: 2/25/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-28-1962
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln
22d. LOCATION (City, town, or county) (State): Bladensburg Md.

23. FUNERAL DIRECTOR: W. W. Chambers Co.
ADDRESS: Riverdale, Md.

24a. REC'D BY REGISTRAR DATE: MAR 1 '62
24b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

02229

CERTIFICATE OF DEATH

02212

1 PLACE OF DEATH
a. COUNTY: Prince George County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Adelphi
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 10105 Green Forest Drive

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md.
b. COUNTY: Prince Geo ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Adelphi
d. STREET ADDRESS: 10105 Green Forest Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First MARY Middle ELIZABETH Last FARROW

4. DATE OF DEATH: Month Feb. Day 16 Year 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 7, 1961
9. AGE (In years last birthday): — yrs
IF UNDER 1 YEAR: Months 11 Days
IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at Home
10b. KIND OF BUSINESS OR INDUSTRY: at Home
11. BIRTHPLACE (State or foreign country): Washington D.C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Walter R. Farrow
14. MOTHER'S MAIDEN NAME: Rose Majewski

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: —
17. INFORMANT: Walter R. Farrow Address: (same as #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute, Fulminating Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Mongolicanism

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Mar. 7 1961, to Feb. 16 1962 that (I) (~~was~~ last saw the deceased alive on 2/16 1962 and that death occurred 6:45 M, from the causes and on the date stated above

22a. SIGNATURE: James L. Haubach M.D
ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 2/16/62
22c. PHYSICIAN'S NAME (Type): James L. Haubach, M.D
22d. ADDRESS: 1806 Fox St Hyattsville Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Feb. 17. 1962
23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery
23d. LOCATION (City, town, or county) (State): Montgomery County, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters
ADDRESS: 29 Carroll St NW. DC.
25a. REC'D BY REG STRAR DATE: FEB 19 62
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A1S (4)
ISM 9/59

1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02230 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02213

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Naylor
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route 382

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Naylor
d. STREET ADDRESS: Route 382
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Wrieglit — Middle: John — Last: Ferguson

4. DATE OF DEATH: Month: Feb — Day: 2 — Year: 1962

5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Aug 17, 1909
9. AGE (In years last birthday): 52 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: General
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Ferguson
14. MOTHER'S MAIDEN NAME: Florence Wrieglit

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 577-26-8559
17. INFORMANT: Elizabeth Ferguson — Address: Same as #2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 4-43 X — DUE TO (b): Acute Congestive heart failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (c): Hypertensive heart disease

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X] Accident [ ] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: James T. Boyd, M.D.
EXAMINER'S NAME (Type): JAMES T. BOYD
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county):
DATE SIGNED: Feb 2, 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan. 5 1962
22c. NAME OF CEMETERY OR CREMATORY: St. Thomas
22d. LOCATION (City, town, or country) (State): Aquasco Md. R.F.D.

23. FUNERAL DIRECTOR: George D. Kelson
ADDRESS: Aquasco Md.

24a. REC'D BY REGISTRAR: FEB 7 '62
DATE

24b. REGISTRAR'S SIGNATURE: Curtis L. Kimmey

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME SM 9 60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02231 Item 9 Film G907 — 2/17/62 iwk — 02214

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN MARYLAND: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): West Hyattsville
d. STREET ADDRESS: 5608 29th Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lovie; Middle: Jacqueline; Last: Flesher

4. DATE OF DEATH: Month: February; Day: 10; Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: September 28, 01 60

9. AGE (In years last birthday): 61 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitres

10b. KIND OF BUSINESS OR INDUSTRY: Food

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Gordon Hannigan

14. MOTHER'S MAIDEN NAME: Willa Lee Turner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 219-36-9407

17. INFORMANT: Address: Nancy Goddard, same as # 2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH
420 c 1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Coronary Artery Disease
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MED CAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒. Inquiry ☒. and in my opinion death resulted from: Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): James I. Boyd

Address (Street, city, town, or county):

DATE SIGNED: 2/11/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb. 14, 1962

22c. NAME OF CEMETERY: Fort Lincoln Cemetery

22d. LOCATION (City, town, or country) (State): Bladensburg, Maryland.

23. FUNERAL DIRECTOR: W. W. CHAMBERS CO.

ADDRESS: Riverdale, Md.

24a. REC'D BY REG.STRAR: DATE: FEB 13 '62

24b. REGISTRAR'S SIGNATURE: Clara L. Kuna

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A1S (4)
1SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02232 02215

1. PLACE OF DEATH
a. COUNTY: Prince Georges County MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 55 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Landover
d. STREET ADDRESS: 1600 Whitehouse Heights
• IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Minerva Middle: ELIZABETH Last: Fletcher

4. DATE OF DEATH: Month: February Day: 18 Year: 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/25/92
9. AGE (In years last birthday): 69 yrs. IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Power
14. MOTHER'S MAIDEN NAME: Belle Schumate
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mr Samuel Fletcher Address: Rome an # 2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
(a) IMMEDIATE CAUSE: Uremia
DUE TO
(b) Kidney insufficiency
DUE TO
(c) bilateral pyelonephritis & nephrosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Rheumatoid arthritis - Pulmonary emphysema

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

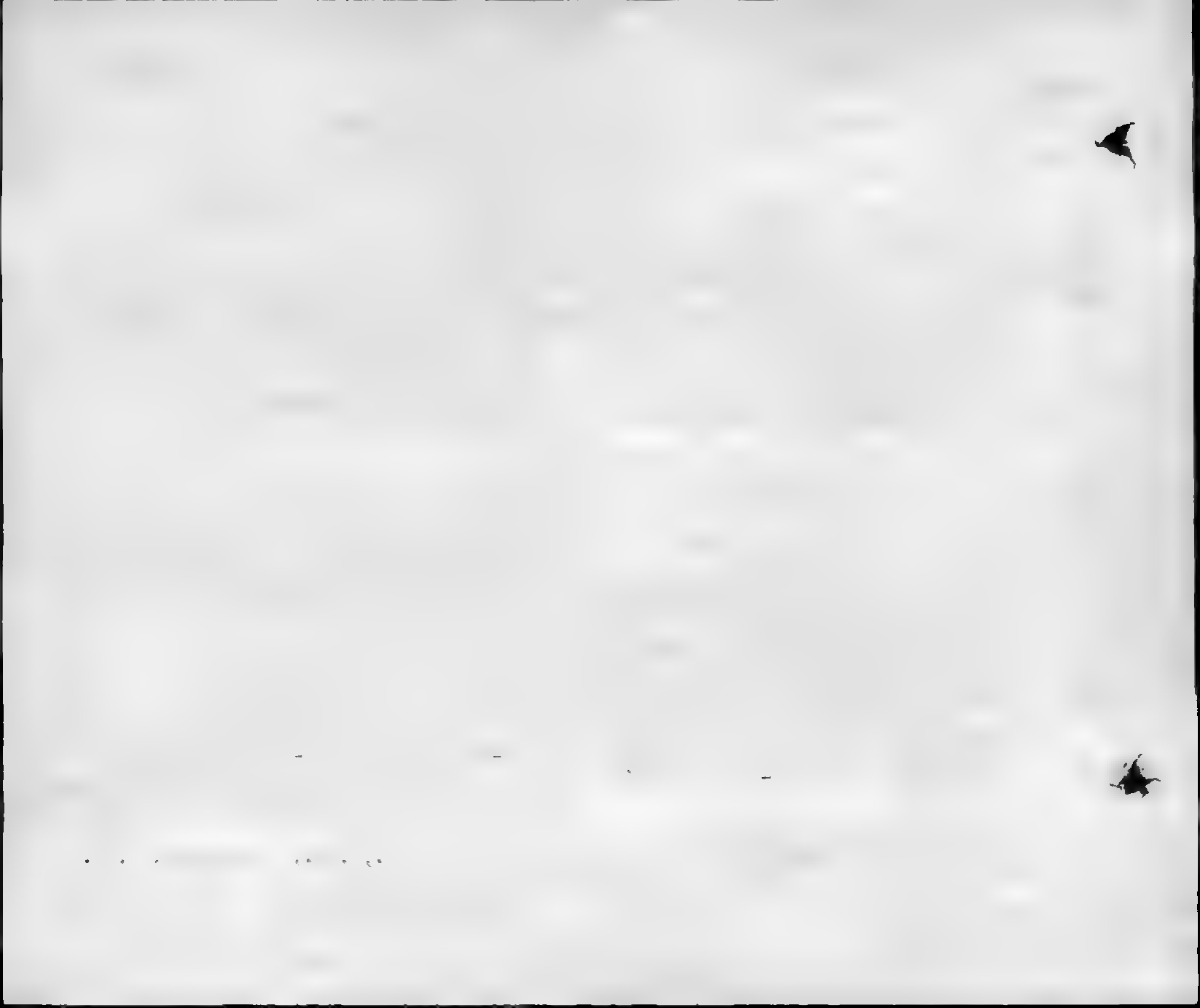
21. I certify that (I) (this hospital) attended the deceased from 12-28, 1962, to 2-18, 1962, that (I) (we) last saw the deceased alive on 2-18 1962, and that death occured at 6:55 P.M. from the causes and on the date stated above

22a. SIGNATURE: Ottavio Gelmi M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Dr. Ottavio Gelmi
22d. ADDRESS: 1801 Eye St., N. W., Washington, D. C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2-21-1962
23c. NAME OF CEMETERY OR CREMATORY: Washington National
23d. LOCATION (City, town or county) (State): Scuttland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: W. W. Chambers Co. Riverdale, Md.

25a. REC'D BY REGISTRAR DATE: FEB 23 '62
25b. REGISTRAR'S SIGNATURE: Dallas S. Evans



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02233 — 02216

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 19 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheltenham
d. STREET ADDRESS: Box 25
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Charles — Middle: L — Last: Foreman

4. DATE OF DEATH: Month: Feb — Day: 27 — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: ~~Black~~ NEGRO

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8 April 1882

9. AGE (In years last birthday): 79 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: MESSENGER U.S. SUPREME CT.

11. BIRTHPLACE (County & State, or foreign country): WASHINGTON, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ? FOREMAN

14. MOTHER'S MAIDEN NAME: VICTORIA ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown. If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.:

17. INFORMANT: MARY FOREMAN-WIFE — Address: BOX 25 CHELTENHAM, MD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 7 days

DUE TO (b): Arteriosclerotic Cardio-vascular-renal disease — Unknown

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8 Feb ..., 1962 to 20 Feb ..., 1962 that (I) (we) last saw the deceased alive on 20 Feb. 1962, and that death occured at 2.50A M from the causes and on the date stated above

22a. SIGNATURE: R R Sasscer — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Dr. R. Sasscer., M.D.

22d. ADDRESS: Upper Marlboro., Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 23b. DATE THEREOF: 3-3-62 — 23c. NAME OF CEMETERY OR CREMATORY: LINCOLN MEMORIAL — 23d. LOCATION City, town or county: SUITLAND, (State) MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE: Alex S. Pope, Jr. — ADDRESS: 414-15TH S.E.

25a. REC'D BY REGISTRAR — DATE: MAR 1 '62 — 25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02234

CERTIFICATE OF DEATH

Reg. Dist. No. 02217

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): West Hyattsville
c. LENGTH OF STAY IN 1b: 9 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 2421 Chapman Rd

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): West Hyattsville
d. STREET ADDRESS: 2421 Chapman Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First MARIE — Middle JOHANNA HENRIETTA — Last Giesecke

4. DATE OF DEATH: Month February — Day 22 — Year 1962

5. SEX: Female
6. COLOR OR RACE: Cauc.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Aug. 9, 1873
9. AGE (In years last birthday): 88 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?: Germany

13. FATHER'S NAME: Johann George
14. MOTHER'S MAIDEN NAME: Maria Winter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Gretchen Bolick — Address: 2421 Chapman Rd. West Hyatts

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral hemorrhage	Days
DUE TO (b)	Cerebral arteriosclerosis	unknown
DUE TO (c)	Generalized arteriosclerosis	unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour — a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Febr. 21, 19 62, to Febr. 22, 1962, that I last saw the deceased alive on Febr. 21, 1962, and that death occurred at 105 p. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Eino Magi, M.D. — ADDRESS (Street, city or town, state): 918 University Blvd. E., Silver Spring, Md. — DATE SIGNED: 2-22-62

PHYSICIAN'S NAME (Type): EINO MAGI

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-24-62
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
22d. LOCATION (City, town, or county): Colmar Manor (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: I. Brashears Sons — ADDRESS: Hyattsville Md.
24a. REC'D BY REGISTRAR DATE: FEB 26 '62
24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02235 02218

1 PLACE OF DEATH
a. COUNTY Prince George
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address or INSTITUTION) 5402-38th Ave 6

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville
d. STREET ADDRESS 5402-38th Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Edward Middle: Andrew Last: Gross

4. DATE OF DEATH Month: Febr Day: 2 Year: 1962

5 SEX: male
6 COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb 21, 1895
9 AGE (In years last birthday): 66 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b KIND OF BUSINESS OR INDUSTRY: Accountant
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13 FATHER'S NAME: George Gross
14. MOTHER'S MAIDEN NAME: Eva Schlundt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWI
16. SOCIAL SECURITY NO.
17. INFORMANT: Gertrude L. Gross Address: Sumner # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Bronchogenic Carcinoma
DUE TO
(b)
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from February 1960 to Feb 2 1962 that (I) ~~(we)~~ last saw the deceased alive on 2-1 1962 and that death occurred at 3:45 AM from the causes and on the date stated above

22a SIGNATURE: Harry N. Carlton, M.D
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 2/2/62
22c PHYSICIAN'S NAME (Type): HARRY N. CARLTON
22d ADDRESS: 940-25th St, NW Wash DC

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/5/62
23c NAME OF CEMETERY OR CREMATORY: Ft Lincoln
23d LOCATION (City, town, or county) (State): Colmar Manor, Md

24 FUNERAL DIRECTOR'S SIGNATURE: Edwards Sons
ADDRESS: Hyattsville Md
25a. REC'D BY REGISTRAR DATE: FEB 6 '62
25b REGISTRAR'S SIGNATURE: Arthur L Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02236 — 02219

1

M

I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edmonston
c. LENGTH OF STAY IN 1b: 25 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4817 48TH Ave

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Md — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edmonston
d. STREET ADDRESS: 4817 48TH Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	Gladys	M.	Hall		Feb	4	1962

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White		May 31, 1906	55 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife	Own Home	Lynchburg Va.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Wade McKenney	Lora ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	No	Husband	James Hall 4817 48th Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis
DUE TO (b): Bronchogenic Carcinoma
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: (a) 1 1/2 yrs; (b) 2 1/2 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m./p.m.	Month, Day, Year	20d. INJURY OCCURRED: While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
	19					

21. **I certify** that (I) (this hospital) attended the deceased from July ..... 19 55 to Feb 4 ..... 19 62 that (I) (we) last saw the deceased alive on Feb 3 ..... 19 62 and that death occured at 1:40 P.M., from the causes and on the date stated above

22a. SIGNATURE	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
Norman Donat Comeau M.D		2/4/62

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Norman Donat Comeau	3503 Penny St Mt. Rainier Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	Feb 1962	Ft. Lincoln	Colmar Manor, Md

24. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Edwards and Kyattsville Md		FEB 7 '62	Arthur L. Kinna

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02237 02220

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oxon Hill, Md.
c. LENGTH OF STAY IN 1b: 3 mo
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: 212 Standish Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Pennsylvania — b. COUNTY: Fayette
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Confluence
d. STREET ADDRESS: 613 Meyers Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Millie — Middle: M — Last: Hall

4. DATE OF DEATH: Month: Feb. — Day: 20, — Year: 1962

5. SEX: F

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Mar. 18 1890

9. AGE (Last birthday) 71 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jackson Myers

14. MOTHER'S MAIDEN NAME: Ella Woodnancy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO:

17. INFORMANT — Address: Mrs Vera Groff 212 Standish Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): HEART ARREST — INTERVAL BETWEEN ONSET AND DEATH: Minutes

DUE TO (b): CEREBRO VASCULAR ACCIDENT — 1 month

DUE TO (c): HYPERTENSIVE ARTERIO SCLEROTIC DISEASE — YEARS.

Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Feb 28, 1961 to Feb 20, 1962, that (I) (we) last saw the deceased alive on Feb. 20, 1962 and that death occurred at A M, from the causes and on the date stated above

22a. SIGNATURE: Miguel A. Huici M.D — ATTENDING PHYS ☑ MED. DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED: 2/20/62

22c. PHYSICIAN'S NAME (Type): Miguol A Huici, M.D.

22d. ADDRESS: 5231 Livingston Rd., S.E.

23a. BURIAL, CREMATION REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb. 23 1962

23c. NAME OF CEMETERY OR CREMATORY: Johnson Chapel

23d. LOCATION (City, town, or county) (State): Fayette Co. Penna.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Pearson Funeral Home, Falls Church, Va.

25a. REC'D BY REGISTRAR — DATE: FEB 21 '62

25b. REGISTRAR'S SIGNATURE: S. Thomas

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

02221

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02238

CERTIFICATE OF DEATH

1. PLACE OF DEATH — a. COUNTY: Prince George — MARYLAND — b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville — c. LENGTH OF STAY IN 1b: 4yrs.10mos. — d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: -- — b. COUNTY: -- — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C. — d. STREET ADDRESS: 4207 Ellicott Street, NW — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Katherine — Middle: — Last: Hanlon

4. DATE OF DEATH: Month: February — Day: 22 — Year: 19 62

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ W.DOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct.18,1879

9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Waxford Co., Ireland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Doyle

14. MOTHER'S MAIDEN NAME: Margaret Foley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: None — Sacred Heart Home Records-#1 abv

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): 420.0 — Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 4 years

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I,a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from 2/19/1950 to 2/22/1962, that (I) (~~XX~~) last saw the deceased alive on 2/21/1962 19..... ., and that death occured at 4:40 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Thomas F Collins M D — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED: 2/22/1962

22c. PHYSICIAN'S NAME (Type): Thomas F. Collins, M.D. — 22d. ADDRESS: 322-H.St.N.E.- Wash.2,D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 2/24/62 — 23c. NAME OF CEMETERY OR CREMATORY: Mt.Olivet — 23d. LOCATION (City, town or county) (State): Washington,D.C.

24 FUNERAL DIRECTOR'S SIGNATURE: G.T.Ryan — Jas.T.Ryan,Inc. — ADDRESS: 317 Pa.Ave.,SE

25a. REC'D BY REGISTRAR DATE: FEB 26 '62 — 25b. REGISTRAR'S SIGNATURE: C.H. Pitman

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02239 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02222

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bladensburg
c. LENGTH OF STAY IN 1b: 15 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4105 53rd Avenue

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bladensburg
d. STREET ADDRESS: 4105 53rd Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ida — Middle: Karlstad — Last: Harley

4. DATE OF DEATH: Month: February — Day: 17 — Year: 19 62

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb. 14, 1895

9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Saleslady

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): S outh Dakota

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Martin M. Karlstad

14. MOTHER'S MAIDEN NAME: Regina Hoff

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Donald Charshee, same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 6 0 0.0 PYELONEPHRITIS — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a): Fatty Infiltration Liver

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II. of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒. Inspection ☒. Inquiry ☒. and in my opinion death resulted from: Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): James I. Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: Feb. 17, 1962

Address (Street, city, town, or county)

22a. BURIAL, CREMATION REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/21/62

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or country) (State): Arlington, Va.

23. FUNERAL DIRECTOR: Francis Gasch's Sons — ADDRESS: Hyattsville, Maryland

24a. REC'D BY REGISTRAR DATE: FEB 20 '62

24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9 60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02240 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 02223

FOR STATE HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 9/60

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hillcrest Heights
c. LENGTH OF STAY IN 1b: 2 month
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 2525 Colebrooke Drive

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hillcrest Heights
d. STREET ADDRESS: 2525 Colebrooke Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Bartlett — Last: Harrell

4. DATE OF DEATH: Month: Feb — Day: 17 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec 15, 1961

9. AGE (In years last birthday): — yrs. IF UNDER 1 YEAR: Months: 2 Days: 2 IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): District of Columbia

12. CITIZEN OF WHAT COUNTRY? U. S. Ca

13. FATHER'S NAME: Hardee LeRoy Harrell

14. MOTHER'S MAIDEN NAME: Marilyn Skennard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Address: Mrs Marilyn S. Harrell, Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒. Inquiry ☒. and in my opinion death resulted from: Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE: James L. Boyd M.D.

EXAMINER'S NAME (Type): JAMES L. Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

DATE SIGNED: 2/17/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb. 20-62

22c. NAME OF CEMETERY OR CREMATORY: Arlington Natl

22d. LOCATION (City, town, or country): Arlington (State): Va

23. FUNERAL DIRECTOR: Simmons Bro. ADDRESS: 1661 - Good Hope Rd SE WA 5th 20 DC

24a. REC'D BY REGISTRAR DATE: FEB 19 '62

24b. REGISTRAR'S SIGNATURE: Lurline S. Travis

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02241 02224

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Andrews Air Force Base
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: USAF Hospital, Andrews AF Base

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Florida
b. COUNTY: Highlands
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lake Placed
d. STREET ADDRESS: Route 1, Box 354
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELEANOR Middle ELIZABETH Last HARRIS

4. DATE OF DEATH: Month February Day 20 Year 1962

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6 April 1894

9. AGE (In years last birthday): 67 yrs
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wayne Pinkerton

14. MOTHER'S MAIDEN NAME: Mary Lee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: —

17. INFORMANT: Wayne P. Litz (As above) — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 1 ~~2~~ ~~3~~ X Cardiovascular Collapse — INTERVAL BETWEEN ONSET AND DEATH: —
DUE TO (b): Superior Vena Cava Obstruction — JUNE 1961
DUE TO (c): Mediastinal neoplasm - possibly metastatic — T. 20 FEB 62

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): NONE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour ___ a. m. p. m. Month, Day, Year ___ 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 10:35 20 FEB. 1962 to 10:46 20 FEB 1962 that (I) ~~(we)~~ last saw the deceased alive on 10:35 AM 20 FEB 1962 and that death occurred at 10:50 AM, from the causes and on the date stated above.

22a. SIGNATURE: William K. Grove Capt USAF MC M.D
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): WILLIAM K. GROVE, Capt USAF MC

22d. ADDRESS: USAF Hospital, Andrews AFB

23a. BURIAL CREMATION REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 27 FEB. 1962

23c. NAME OF CEMETERY OR CREMATORY: LAKE PLACID CEMETERY

23d. LOCATION (City, town, or county) (State): LAKE PLACID FLORIDA

24. FUNERAL DIRECTOR'S SIGNATURE: Rinaldi Funeral Home Inc. — ADDRESS: 1401 GEORGIA AVE. NW. DC 12

25a. REC'D BY REGISTRAR DATE: FEB 23 '62

25b. REGISTRAR'S SIGNATURE: Carlton L. Truax

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with n 24 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: ... after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

Item 20 Film 307 2-26-62

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02242 — 02225

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Oakland
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 6301 Marlboro Pike S.E.

2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prinee George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hillside
d. STREET ADDRESS:
• IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Richard Middle Newton Last Hayes
4. DATE OF DEATH: Month February Day 17 Year 19 62
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: Feb. 15, 1895
9. AGE (In years last birthday): 67 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Richard Newton Hayes
14. MOTHER'S MAIDEN NAME: Marion W Hagan
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes W.W.I
16. SOCIAL SECURITY NO: Yes ?579-03-2??-?
17. INFORMANT: Esther Richardson 2209 Jamerson St. Hillcrest Hghts, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Shock
DUE TO (b): Universal Burns of the body
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

916.8

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Living in an abandoned bus that caught on fire
20c. TIME OF INJURY Hour 10:I p.m. Month, Day Year 2-17 19 62
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): 6301 Marlboro Pike
20f. (City or town) Oakland (County) Pr. Geo. (State) Md.

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.
EXAMINER'S NAME (Type): James I. Boyd
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: Feb. 17, 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-23-1962
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or country) (State): Arlington, Virginia
23. FUNERAL DIRECTOR: W.W. Chambers Co. ADDRESS: Riverdale, Md.
24a. REC'D BY REGISTRAR DATE: FEB 23 '62
24b. REGISTRAR'S SIGNATURE:

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director as soon as possible. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 9'60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G307 2/20/62 iwk

CERTIFICATE OF DEATH

02243

Reg. Dist. No. 02226

1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Washington
c. LENGTH OF STAY IN 1b 11 yrs
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Prince Geo. Co. Rest Home

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE Maryland
b. COUNTY Pr Geo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Born in Washington DC
d. STREET ADDRESS 6 [illegible] Marlboro Rd Md Rte 4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First: Carrie Middle: Jones Lost: Henson

4. DATE OF DEATH Month: Feb Day: 14 Year: 1962

5. SEX: Fem

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 25 1868

9. AGE (In years last birthday): 93 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dress Maker

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Providence R.I.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William H. Henson

14. MOTHER'S MAIDEN NAME: Letticia Small

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): unknown

16. SOCIAL SECURITY NO.: —

INFORMANT Address: Records Prince Geo. Co. Rest Home

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 7 days

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b): Arterio Sclerotic Cardio Vascular Renal Disease — INTERVAL BETWEEN ONSET AND DEATH: Unknown

DUE TO (c): (Senile)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.): Natural Causes

20c. TIME OF INJURY Month, Day, Year, Hour a m / p m — 19

20d. INJURY OCCURRED White at work ☐ Not white at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office b dg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 1, 1962 to Feb 14, 1962 that I last saw the deceased alive on Feb 12, 1962, and that death occurred at 9 10 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Paul C VanNatta M.D

ADDRESS (Street, city or town state): 5440 Silver Hill Rd SE

DATE SIGNED

PHYSICIAN'S NAME (Type): PAUL C VANNATTA

Washington 28 DC.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 2-16-62.

22c. NAME OF CEMETERY OR CREMATORY: Mt Olivet

22d. LOCATION (City, town, or county) (State): Washington, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: The Hunte Funeral Home, Waldorf, MD.

24a. REC'D BY REGISTRAR DATE: FEB 16 '62

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02244

CERTIFICATE OF DEATH

02227

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
c. LENGTH OF STAY IN 1b: D. O. A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): enroute to Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): College Park
d. STREET ADDRESS: 9704 52nd Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elwin; Middle: ; Last: Holcombe

4. DATE OF DEATH: Month: Feb.; Day: 8; Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Oct 10, 1921

9. AGE (In years last birthday): 40 yrs.

IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supervisor

10b. KIND OF BUSINESS OR INDUSTRY: Navy Dept

11. BIRTHPLACE (County & State, or foreign country): Georgia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: J. Carl Holcombe

14. MOTHER'S MAIDEN NAME: LuluBelle Ridings

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes - 1941 -

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Louise Holcombe Address: (same)

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Uremia	6 months
DUE TO (b)	Hypertensive Heart Disease	5 years
DUE TO (c)	Diabetes Mellitus	20 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

MEDICAL CERTIFICATION

21. I certify that (I) ~~(this hospital)~~ attended the deceased from October, 1961 to Feb 8, 1962, that (I) (we) last saw the deceased alive on Feb 1, 1962, and that death occured at 11:00 AM from the causes and on the date stated above.

22a. SIGNATURE: J. Frederick Bair M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): J. Frederick BAKR, MD

22d. ADDRESS: 4501 College Ave, College Park, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Transportation

23b. DATE THEREOF: 2/8/62

23c. NAME OF CEMETERY OR CREMATORY: Canton

23d. LOCATION (City, town or county) (State): Georgia

24 FUNERAL DIRECTOR'S SIGNATURE: F. Gasch's Sons

ADDRESS: Hyattsville, Md.

25a. REC'D BY REGISTRAR DATE: FEB 13 '62

25b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02245 — Item 8 filed 6306 2/7/62 jwk — 02228

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): [illegible] E Riverdale
d. STREET ADDRESS: 6215 61st Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Paul — Middle: — Last: Holeva

4. DATE OF DEATH: Month: Feb — Day: 24 — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 29 Sept. 1877

9. AGE (In years last birthday): 85 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (County & State, or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unknown (If yes give war or dates of service)

16. SOCIAL SECURITY NO: Unknown

17. INFORMANT: Hospital Records — Address: Cheverly, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): 1) Congestive Heart Failure

DUE TO (b): 2) Arteriosclerotic Heart Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): 3) generalized Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2-22, 1962 to 2-24, 1962., that (I) (we) last saw the deceased alive on 2-24 19 62, and that death occured at 1.10AM from the causes and on the date stated above.

22a. SIGNATURE: Cesar M. Madarang M.D.

22b. DATE SIGNED

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): Dr. M. Madarang

22d. ADDRESS: Prince George's General Hosp., Cheverly, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/28/61

23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery

23d. LOCATION (City, town or county) (State): Colmar Manor Md.

24. FUNERAL DIRECTOR'S SIGNATURE: F. Gasch's Sons

ADDRESS: Hyattsville, Md.

25a. REC'D BY REGISTRAR DATE MAR 1 '62

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

As Mr. Paul Haleva had no living relatives and a friend Mr. Alexander Hamilton assumed responability for the funeral we were unable to gather any further information for the death certificate

from the desk of

WM. ERNEST GASCH

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02246 02229

1

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANDREWS AIR FORCE BASE
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: US AIR FORCE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: DISTRICT OF COLUMBIA
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON
d. STREET ADDRESS: 5203 25TH AVENUE SE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARROLD Middle LUTHER Last HOLTMANN

4. DATE OF DEATH: Month FEBRUARY Day 6 Year 19 62

5. SEX: MALE

6. COLOR OR RACE: CAUCASIAN

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 17 SEPTEMBER 1920

9. AGE (In years last birthday): 41 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): OFFICER

10b. KIND OF BUSINESS OR INDUSTRY: US AIR FORCE

11. BIRTHPLACE (State or foreign country): OKLAHOMA

12. CITIZEN OF WHAT COUNTRY?: UNITED STATES

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: KATHRYN MARIE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES
(If yes, give war or dates of service): 1943-PRESENT

16. SOCIAL SECURITY NO: 442-16-3413

17. INFORMANT: PERSONNEL RECORDS — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): HEMORRHAGIC DIATHESIS — INTERVAL BETWEEN ONSET AND DEATH: 20 HOURS

DUE TO (b): CHRONIC DECOMPENSATED LIVER DISEASE — UNKNOWN

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~XXXXXXXX~~) attended the deceased from 5 FEBRUARY 19 62, to 6 FEBRUARY 19 62, that (I) (XX) last saw the deceased alive on 6 FEBRUARY 19 62, and that death occurred at 6P M, from the causes and on the date stated above

22a. SIGNATURE: Bernard F Clowdus M.D

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 6 FEB 62

22c. PHYSICIAN'S NAME (Type): BERNARD F CLOWDUS, Capt USAF MC

22d. ADDRESS: USAF HOSPITAL, ANDREWS AIR FORCE BASE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): SHIP. AK.

23b. DATE THEREOF: 2-8-62

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county) (State): MUSKOGEE OKLAHOMA

24. FUNERAL DIRECTOR'S SIGNATURE: W.W. Chambers Co

ADDRESS: 517-11th SE Washington DC

25a. REC'D BY REGISTRAR DATE: FEB 9 '62

25b. REGISTRAR'S SIGNATURE: C. Jim S. Evans

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER. This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02247 02230

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kennelworth
d. STREET ADDRESS: 1708 Kennelworth Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First Sidney — Middle — Last Horsey
4. DATE OF DEATH: Month February — Day 24, — Year 19 62
5. SEX: Male
6. COLOR OR RACE: colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 29, 1932
9. AGE (In years last birthday): 30 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Property Clerk
10b. KIND OF BUSINESS/INDUSTRY: Hospital St. Elizabeth
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Sidney Stevenson
14. MOTHER'S MAIDEN NAME: Frances Horsey
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Yes Korean
16. SOCIAL SECURITY NO.: 217-28-3381
17. INFORMANT: Howard Horsey — Address: (Same as two)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 781X
DUE TO (b): Shock & Hemorrhage
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c): Stab wound of chest
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH ☒
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Stabbed in chest during an altercation
20c. TIME OF INJURY: Hour 1:28 a.m. p.m. XX — Month, Day, Year 2/24/62
20d. INJURY OCCURRED: While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) Kennelworth (County) P. G. (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐ inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE: James J. Boyd M.D.
EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 2/24/62
Address (Street, city, town, or county):

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: Feb 30
22c. NAME OF CEMETERY OR CREMATORY: MT. PEAT
22d. LOCATION (City, town, or country): MARION (State): Md
23. FUNERAL DIRECTOR: Anthony E. Ward Crisfield Md.
ADDRESS
24a. REC'D BY REGISTRAR — DATE: MAR 5 '62
24b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02248 — 02231

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S 4
1SM 7 61

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): College Park
d. STREET ADDRESS: 9027 49th Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Herman — Middle: R. — Last: Hunt
4. DATE OF DEATH: Month: February — Day: 19 — Year: 19 62
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-26-78
9. AGE (In years last birthday): 83 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Engineer
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Goverment
11. BIRTHPLACE (County & State, or foreign country): Mass.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Josiah A. Hunt
14. MOTHER'S MAIDEN NAME: Julia Reynolds
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Mrs. Cora G. Hunt Same as #2 (Wife)

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Peripheral Vascular Collapse	12 hrs
DUE TO (b)	Mesenteric Thuombosis, Acute	12 hrs
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 19 53 to Feb 19 1962, that (I) (we) last saw the deceased alive on Feb 19 1962, and that death occured at 11:3 AM, from the causes and on the date stated above.

22a. SIGNATURE: Norman Donat Comeau M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED: 2/19/62
22c. PHYSICIAN'S NAME (Type): Norman Donat Comeau — 22d. ADDRESS: 3503 Penny St Mt Rainier Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 2/22/62 — 23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln — 23d. LOCATION (City, town or county, (State)): Colmar Manor, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Francis Gasch's Sons — ADDRESS: Hyattsville, Md.

25a. REC'D BY REGISTRAR DATE: FEB 23 '62 — 25b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02249 Reg. Dist. No. 02232

1. PLACE OF DEATH
a. COUNTY Prince George MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier
c. LENGTH OF STAY IN 1b 51 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4019-36th Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
STATE Maryland b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt Rainier 47
d. STREET ADDRESS 4019-36th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Josephine Middle (NMI) Last Hutchinson
4. DATE OF DEATH Month Feb. Day 15 Year 1962
5. SEX F
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 17 Oct. 1870
9. AGE (In years last birthday) 91 yrs
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hotel Worker
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Va.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME James G. Mastin
14 MOTHER'S MAIDEN NAME Mary Cathrine Lumsden

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16 SOCIAL SECURITY NO No
INFORMANT Margaret Cathrine Address Hazel

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest from cachexia
433.0
DUE TO (b) and myocardial insufficiency of
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) generalized arteriosclerosis
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m.
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 19 Jan 57, 19____, to 15 Feb, 1962, that I last saw the deceased alive on 12 Feb, 1962 and that death occurred at 4:30 M, from the causes and on the date stated above

ACTUAL SIGNATURE Thomas E. Mattingly, M.D. M.D
ADDRESS (Street, city or town, state) 2200 Rhode Is. Ave. N.E. Wash. 18, D.C.
DATE SIGNED
PHYSICIAN'S NAME (Type) Thomas E. Mattingly, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 2/17/62
22c NAME OF CEMETERY OR CREMATORY Fort Lincoln
22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.

23 FUNERAL DIRECTOR'S SIGNATURE Malloy's Funeral Home
ADDRESS Mt. Rainier Md.
24a. REC'D BY REGISTRAR DATE FEB 19 '62
24b. REGISTRAR'S SIGNATURE Esther S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the ... director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02250

CERTIFICATE OF DEATH

02233

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: Prince George
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
c. LENGTH OF STAY IN 1b: MARYLAND 2 weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Laurel General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
d. STREET ADDRESS: Box 568A Star Route
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Mary; Middle: Anna; Last: Iager

4. **DATE OF DEATH**: Month: February; Day: 10; Year: 19 62

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4/16/1887

9. AGE (In years last birthday): 74 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Nicholas Musgrove

14. MOTHER'S MAIDEN NAME: Margaret [illegible]

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Hospital Records Address

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Infarction

DUE TO (b): Coronary Thrombosis

DUE TO (c): " "

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1-24 ..... 1962 to 2-10 ..... 1962, that (I) (~~we~~) last saw the deceased alive on 2-10 ..... 1962, and that death occured at 6:35 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Idolo Pierandrei M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Idolo Pierandrei, M.D.

22d. ADDRESS: 305 Prince George Street, Laurel, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial Feb 12, 1962

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY: St Paul's Cem

23d. LOCATION (City, town or county) (State): Fulton, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: [signature] ADDRESS

25a. REC'D BY REGISTRAR DATE FEB 16 '62

25b. REGISTRAR'S SIGNATURE: Cullen L Howe

2 1

FOR STATE HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02251 Item 14 Film G508 2/13/62 lwk 02234

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: MARYLAND 2 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 31 Deanwood Park
d. STREET ADDRESS: 5216 Maple Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Daisy; Middle: ; Last: Jackson

4. DATE OF DEATH: Month: February; Day: 27; Year: 19 62

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 1908

9. AGE (In years last birthday): 53 yrs. IF UNDER 1 YEAR: Months: ; Days: IF UNDER 24 HRS: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Jim Smith

14. MOTHER'S MAIDEN NAME: Mary unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: No

17. INFORMANT: George Jackson, same as # 2 — Address:

18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 4427 Cerebravasoular accident
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c): Cardiovascular renal disease

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour: a.m. p.m. Month: Day: Yr: 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

DATE SIGNED: 2/28/62

22a. BURIAL, CREMATION, REMOVAL (Specify): 3-3-62

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY: Nat Harmony

22d. LOCATION (City, town, or country) (State): Highland Pk Md

23. FUNERAL DIRECTOR: Henry S Washington & Son

ADDRESS: 4925 Hunter Pl

24a. REC'D BY REGISTRAR: DATE MAR 6 '62

24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 9 60

FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02252 02235

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: MARYLAND — D O A
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Capitol Heights
d. STREET ADDRESS: 6117 Kingston Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Louis — Middle: Edward — Last: Jarboe

4. DATE OF DEATH: Month: Feb. — Day: 8 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 12, 1910

9. AGE (In years last birthday): 51 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Handler

10b. KIND OF BUSINESS OR INDUSTRY: Railway Express

11. BIRTHPLACE (State or foreign country): Washington D. C.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Benjamin E. Jarboe

14. MOTHER'S MAIDEN NAME: Margret Lena Heisler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: James J. Jarboe

Address: Radiant Valley, 6901 Stanish Drive Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CEREBRAL HEMORRHAGE

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒. Inspection ☒. Inquiry ☒. and in my opinion death resulted from: Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 2/8/62

EXAMINER'S NAME (Type): James I. Boyd MD.

Address (Street, city, town, or county): 8200 Marlboro Pike, Forestville, Md.

22a. BURIAL, XXXXXX XXXXXX (Specify): Burial

22b. DATE THEREOF: Feb.12,1962

22c. NAME OF CEMETERY: Washington National

22d. LOCATION (City, town, or country) (State): Suitland, Maryland.

23. FUNERAL DIRECTOR: W. W. CHAMBERS CO.,

ADDRESS: Riverdale, Md.

24a. REC'D BY REGISTRAR DATE: FEB 13 '62

24b. REGISTRAR'S SIGNATURE:

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02253 Items 7,8,9,10a,11,12,13 & 14 Film G307 2/15/62 iwk

02237

1. PLACE OF DEATH
a. COUNTY: Prince Georges
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Fairmont Heights
d. STREET ADDRESS: 612 60th Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Florence; Middle: ; Last: Johnson

4. DATE OF DEATH: Month: Feb; Day: 3; Year: 19 62

5. SEX: Female

6. COLOR OR RACE: Black

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED [XX]

8. DATE OF BIRTH: Oct. 15, 1880

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City or town, State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John H. Fltcher

14. MOTHER'S MAIDEN NAME: Mary Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.

17. INFORMANT: Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Intestinal Obstruction — INTERVAL BETWEEN ONSET AND DEATH: 10 Days

DUE TO (b): Volvulus of Cecum — 10 Days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Postoperative Laparotomy, Reduction of Volvulus and Cecostomy

19. WAS AUTOPSY PERFORMED? YES ☐ NO [X]

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from 1/30 19 62 to 2/3 19 62 that I (we) last saw the deceased alive on 2/3 19 62, and that death occured at 4.10 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Wm P. Holbrook M.D.

ATTENDING PHYS. [X] MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/5/62

22c. PHYSICIAN'S NAME (Type): Dr. William A. Holbrook

22d. ADDRESS: 4500 College Avenue, College Park, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2-7-62

23c. NAME OF CEMETERY OR CREMATORY: Homans Park

23d. LOCATION (City, town or county) (State): Sheriff Rd. & Palmer Hwy. Md.

24 FUNERAL DIRECTOR'S SIGNATURE: James W. Edmonson

ADDRESS: 909 Bladensburg Rd. N.W.

25a. REC'D BY REG STRAR DATE: FEB 9 '62

25b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02254

CERTIFICATE OF DEATH

02238

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Prince Georges
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenn Dale (rural)
c. LENGTH OF STAY IN MARYLAND: 1 yr., 5 mos, and 26 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Glenn Dale Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: D. C.
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 41
d. STREET ADDRESS: D.C. Village
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert; Middle: —; Last: Johnson

4. DATE OF DEATH: Month: 2; Day: 12; Year: 19 62

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: ? ? 1908

9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months —; Days —
IF UNDER 24 HRS.: Hours —; Min —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown (employed)

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (County & State, or foreign country): S.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Johnson

14. MOTHER'S MAIDEN NAME: Lennie ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: Unknown (lost)

17. INFORMANT: Decedent
Address: —

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Syphilitic aortitis with aortic insufficiency — DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — (b) — DUE TO — (c)

INTERVAL BETWEEN ONSET AND DEATH: unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebrovascular accident (1951) with residual left hemiparalysis; generalized atherosclerosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of Item 18):

20c. TIME OF INJURY: Hour — a.m. p.m. — Month, Day, Year — 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8/17/10:10 1960, to 2/12/, 19 62 that (I) (we) last saw the deceased alive on 2/12/ 19 62, and that death occured at A. M, from the causes and on the date stated above

22a. SIGNATURE: Moe Weiss

22b. DATE SIGNED: 2/12/62

M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): Moe Weiss, M.D.

22d. ADDRESS: Glenn Dale Hospital, Glenn Dale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2-17-1962

23c. NAME OF CEMETERY OR CREMATORY: Harmony Memorial Park

23d. LOCATION (City, town or county) (State): Huntsville, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Mahan-Schey Inc. 424 R St N.W.

25a. REC'D BY REGISTRAR DATE: FEB 19 '62

25b. REGISTRAR'S SIGNATURE: Owen L. Kroon

VR A15 (4)
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02255

CERTIFICATE OF DEATH

02239

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
15M 7 61

1. PLACE OF DEATH
a. COUNTY: Prince Georges
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenn Dale (rural)
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Glenn Dale Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: D. C.
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 428 E. St., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Willie; Middle: —; Last: Johnson

4. DATE OF DEATH: Month: 2; Day: 23; Year: 1962

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1903?

9. AGE (In years last birthday): 58? yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Night-watchman

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (County & State, or foreign country): N.C.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give wer or dates of service): Unknown

16. SOCIAL SECURITY NO: —

17. INFORMANT: Casualty Hospital
Address: Washington, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Intracerebral hemorrhage with right hemiparalysis — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO (b): 443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c): Hypertensive cardiovascular disease, unknown

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Recurrent thrombosis of left middle cerebral artery

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12/8/1961 to 2/23/1962, that (I) (we) last saw the deceased alive on 2/23/1962, and that death occured at 1:05 A.M., from the causes and on the date stated above

22a. SIGNATURE: Moe Weiss

22b. DATE SIGNED: 2/23/62

22c. PHYSICIAN'S NAME (Type): Moe Weiss, M.D.

M.D. ATTENDING PHYS ☐ MED. DIRECTOR ☒ STAFF PHYS ☐

22d. ADDRESS: Glenn Dale Hospital
Glenn Dale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2-27-1962

23c. NAME OF CEMETERY OR CREMATORY: Harmony Memorial Park

23d. LOCATION (City, town or county) (State): Huntsville, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Mahan-Lehey Inc.
ADDRESS: 424 4½ St. N.W.

25a. REC'D BY REGISTRAR DATE: FEB 26 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Frame

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

62256 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02240

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Beltsville
c. LENGTH OF STAY IN MARYLAND: 47
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 5402 O'Dell Road

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Beltsville
d. STREET ADDRESS: 5402 O'Dell Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Hester; Middle: Virginia; Last: King

4. DATE OF DEATH: February 26, 1962

5. SEX: emale

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 20, 1893

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Morton Brown

14. MOTHER'S MAIDEN NAME: Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.

17. INFORMANT: Douglas William King, same as # 2
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): HEMORRHAGE AND Shock

981X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Gunshot wound of chest
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PROBABLE ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Shot during an altercation in her home

20c. TIME OF INJURY: Hour 2 p.m. Month, Day, Year: 2/26/ 19 62

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town): Beltsville (County): P.G. (State): Md

21 **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M D

EXAMINER'S NAME (Type): James I. Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 2/26/62

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 3-3-62

22c. NAME OF CEMETERY OR CREMATORY: Warrenton Am.

22d. LOCATION (City, town, or country): Warrenton (State): Virginia

23. FUNERAL DIRECTOR: Henry S Washington & Son

ADDRESS: 4925 Decatur Ave NE

24a. REC'D BY REGISTRAR DATE: MAR 1 '62

24b. REGISTRAR'S SIGNATURE: Clifton L. Evans

1

FOR STATE HEALTH DEPT.

M

I

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director as. 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be returned for your files.

TO FUNERAL DIRECTOR. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02257 02211

1. PLACE OF DEATH
a. COUNTY: Prince Georges
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
c. LENGTH OF STAY IN: MARYLAND D. C. A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Pr. Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 6903 3rd Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ARTHUR Middle: JAMES Last: KRAUSE

4. DATE OF DEATH: Month: Feb. Day: 2 Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 4, 1875

9. AGE (In years last birthday): 86 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Plumber

11. BIRTHPLACE (State or foreign country): Wash. D. C.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wars or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Frank J. Sheahan Address: Wash. D. C. 818 Randolph St.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO: Cardiovascular renal disease

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒. Inquiry ☒. and in my opinion death resulted from. Natural causes ☒. Accident ☐. Suicide ☐ Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): James I. Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

DATE SIGNED: 2-3-62

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 2-5-62

22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cem.

22d. LOCATION (City, town, or country) (State): Bladensburg Md.

23. FUNERAL DIRECTOR ADDRESS: Hanlon Funeral Home — Wash. D. C.

24a. REC'D BY REGISTRAR DATE: FEB 8 '62

24b. REGISTRAR'S SIGNATURE: [illegible]

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02258 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 02242

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used for burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: MARYLAND D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Landover
d. STREET ADDRESS: Ardwick Road Rt #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mable; Middle: Blair; Last: Lampkin

4. DATE OF DEATH: Month: Feb.; Day: 5; Year: 1962

5. SEX: F

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug 23, 1901

9. AGE (In years last birthday): 60 yrs. IF UNDER 1 YEAR: Months: 5; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henery Blair

14. MOTHER'S MAIDEN NAME: Unkown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Redvers Lampkin Same as #2 Address:

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 416 x
DUE TO (b): Acute congestive heart failure
DUE TO (c): Rheumatic heart disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Jamar D Boyd MD

EXAMINER'S NAME (Type): James I. Boyd, MD

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: February 6, 1962

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): 2-9-1962

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY: Carver Mem. Park

22d. LOCATION (City, town, or country): Md. (State)

23. FUNERAL DIRECTOR: Frazier's Funeral Home, Inc. 384-R.D. ADDRESS: 2nd NW

24a. REC'D BY REGISTRAR DATE: FEB 9 '62

24b. REGISTRAR'S SIGNATURE: Luther S. Mann

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02259 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 02243

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: Prince George's — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Camp Springs
   c. LENGTH OF STAY IN 1b: D.O.A.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Andrews Airbase Hospital

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Prince George's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 19 Camp Springs
   d. STREET ADDRESS: 5425 Branch Avenue
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: William — Middle: Dow — Last: Landreth

4. **DATE OF DEATH**: Month: February — Day: 2 — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 2, 1958

9. AGE (In years last birthday): 3 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): District of Columbia U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Hubert Landreth

14. MOTHER'S MAIDEN NAME: Patsy L. Balderson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT — Address: William Hubert Landreth, same as # 2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Asphyxia

DUE TO (b): Acute carbon monoxide poisoning

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Occupant of house that burned

20c. TIME OF INJURY: Hour: 9:15 a.m. p.m. XX — Month, Day, Year: 2/2/19 62

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home — (City or town): Camp Springs P.G. — (County): — (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): James I. Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 2/2/62

Address (Street, city, town, or county):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 2-5-1962 — 22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill — 22d. LOCATION (City, town, or country): Suitland Md (State):

23. FUNERAL DIRECTOR: Robert A Mattingly Wash D C — ADDRESS: 131-11 St

24a. REC'D BY REGISTRAR — DATE: FEB 5 '62

24b. REGISTRAR'S SIGNATURE

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02260 — 02211

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lanham
c. LENGTH OF STAY IN 1b: 4 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 5402 Whitfield Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lanham
d. STREET ADDRESS: 5402 Whitfield Road — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Douglas — Middle: Everett — Last: Larson

4. DATE OF DEATH: Month: Feb — Day: 18 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 24 1924

9. AGE (In years last birthday): 37 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Drug

11. BIRTHPLACE (State or foreign country): Montana

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Clarence Benjamin Larson

14. MOTHER'S MAIDEN NAME: Louise Evonne Viewig

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes — WW II

16. SOCIAL SECURITY NO: 501-28-2314

17. INFORMANT: Richard Eugene Larson — Address: same as #2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 974 X — DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO (c)

Asphyxia
Hanging

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Hanged self in closet of home

20c. TIME OF INJURY: Hour: 11:30 a.m. — Month, Day, Year: 2-18 1962

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town): Lanham — (County): P G — (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☐, Accident ☐, Suicide ☒ Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd, M.D.
NAME (Type): JAMES I. BOYD
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED: 2/18/62

22a. BURIAL, CREMATION, XXXXX (Specify): Cremation
22b. DATE THEREOF: Feb. 23, 1962
22c. NAME OF XXXX OR CREMATORY: Fort Lincoln Cemetery
22d. LOCATION (City, town, or country): Bladensburg (State): Maryland.

23. FUNERAL DIRECTOR: W. W. Chambers Co.
ADDRESS: Riverdale, Md.

24b. REC'D BY REGISTRAR: DATE: FEB 23 '62
24c. REGISTRAR'S SIGNATURE: [signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9'60

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02261

CERTIFICATE OF DEATH

Reg. Dist. No. 02245

1. PLACE OF DEATH
a. COUNTY Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville
c. LENGTH OF STAY IN 1b: 10 Months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md — b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md
d. STREET ADDRESS 7106 23rd Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY — Middle C — Last LAWRENCE

4. DATE OF DEATH: Month Feb — Day 26 — Year 1962

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 28, 1961
9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months 10 — Days — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country): Wash DC
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: RICHARD LAWRENCE
14. MOTHER'S MAIDEN NAME: ROSEMARY BLIGH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO —
17. INFORMANT: Address FATHER

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Malnutrition
DUE TO (b): Congenital obstruction of Biliary apparatus
DUE TO (c): —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH: Since Birth

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —
20c. TIME OF INJURY Hour — Month — Day — Year 19 — a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4-28, 1961, to 2-26, 1962, that I last saw the deceased alive on 4-28, 1961, and that death occurred at 10:17 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles A Millwater M.D.
ADDRESS (Street, city or town, state): 2434 - 16th St NW
DATE SIGNED: 2/26/62
PHYSICIAN'S NAME (Type): CHARLES A MILLWATER

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: FEB 27 1962
22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet
22d. LOCATION (City, town, or county) (State): Wash. D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: W. Latour
ADDRESS: 3603 14th St. NW Wash DC

24a. REC'D BY REGISTRAR DATE FEB 27 '62
24b. REGISTRAR'S SIGNATURE: Courtney S. Kinnie

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02262 02246

1. PLACE OF DEATH a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Adelphi
c. LENGTH OF STAY IN 1b: 3 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Paint Branch Nursing Home 3120 Powder Mill Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE: --- b. COUNTY: ---
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.
d. STREET ADDRESS: 1725 17th Street, N.W. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Josephine Middle: Weed Last: LeButt
4. DATE OF DEATH: Month: February Day: 16 Year: 19 62

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: MARCH 24, 1877
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maine
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Weed
14. MOTHER'S MAIDEN NAME: Mary Maude Wheeler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: 6916 Granby Street, Mrs Maurice Roman, Bethesda, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 4 4 2 X — Acute congestive heart failure
DUE TO (b): Cardiovascular renal disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.
EXAMINER'S NAME (Type): James I. Boyd
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED: 2/16/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 2/19/62
22c. NAME OF CEMETERY OR CREMATORY: Mount Hope
22d. LOCATION (City, town, or country) (State): North Attleboro, Mass.

23. FUNERAL DIRECTOR: The S.H.Hines Co.- ADDRESS: 2901 14th St., N.W. Washington 9, D.C.
24a. REC'D BY REGISTRAR DATE: FEB 19 '62
24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 9,60

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Ch of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME SM 9 60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02263 02247

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mount Rainier
d. STREET ADDRESS: 3724 34th. Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elmer; Middle: Smith; Last: Little

4. DATE OF DEATH: Month: February; Day: 27; Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 27, 1892

9. AGE (In years last birthday): 70 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter (Ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Building

11. BIRTHPLACE (State or foreign country): Westminister, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Emanuel O. Little

14. MOTHER'S MAIDEN NAME: Harriett Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WWI

16. SOCIAL SECURITY NO: Yes, Unknown

17. INFORMANT: Mr. Arthur R. Wilcoxen, Address: 3724 34th St. Mt. Rainier, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): ~~1~~ ~~2~~ ~~3~~ X Exhaustion — INTERVAL BETWEEN ONSET AND DEATH

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Metastasis to bone

DUE TO (c): Carcenoma of Prostate

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

DATE SIGNED: 2/28/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/2/62

22c. NAME OF CEMETERY OR CREMATORY: St. John's Church

22d. LOCATION (City, town, or country) (State): Beltsville, Md.

23. FUNERAL DIRECTOR: Francis Gasch's Sons

ADDRESS: Hyattsville, Maryland

24a. REC'D BY REGISTRAR: MAR 2 '62

24b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02264

CERTIFICATE OF DEATH

02248

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. **PLACE OF DEATH** — a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenn Dale (RURAL)
c. LENGTH OF STAY IN 1b: 2 mo's,5 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Glenn Dale Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution, Residence before admission)
a. STATE: D.C. — b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1305 - G. St., N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: George — Middle: R. — Last: Litz

4. **DATE OF DEATH**: Month: February — Day: 25 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-26-95

9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cab driver

10b. KIND OF BUSINESS OR INDUSTRY: Hacker

11. BIRTHPLACE (County & State, or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George R. Litz

14. MOTHER'S MAIDEN NAME: Anna Ford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give wer or dates of service): World War I

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: Decedent — Address

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 1 1 2.1
DUE TO (b): Bronchogenic carcinoma, right lung, with associated pneumonitis, metastases to left lung, lymph nodes and adrenals
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cirrhosis of the liver, post necrotic type, with portal hypertension(ascites,esophageal varices);paraplegia, cause unknown;tuberculosis,lymph nodes, right hilum.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12/20/61 11:02 19..., to 2/25, 1962, that (I) (we) last saw the deceased alive on 2/25 1962, and that death occured at 11:02 P.M. from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS ☐

22b. DATE SIGNED: 2/27/62

22c. PHYSICIAN'S NAME (Type): Moe Weiss

22d. ADDRESS: GLENNDALE HOSPITAL GLENNDALE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 3/1/1962 — 23c. NAME OF CEMETERY OR CREMATORY: Arlington National — 23d. LOCATION (City, town or county) (State): Arlington, Va.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: W. W. Chambers Co., Riverdale, Md.

25a. REC'D BY REGISTRAR DATE MAR 5 '62 — 25b. REGISTRAR'S SIGNATURE: [signature]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02265

CERTIFICATE OF DEATH

02249

1. **PLACE OF DEATH**
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN: MARYLAND 15 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Rainier
d. STREET ADDRESS: 3104 Taylor Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: FRANCES Middle: J. Last: LORING

4. DATE OF DEATH: Month: Feb Day: 21 Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2-27-87

9. AGE (In years last birthday): 74 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (City & State or foreign country): Joliet, Illinois

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Myron Van Allen

14. MOTHER'S MAIDEN NAME: Ellen Shields

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Florence E. LoJacono, Daughter Address: 3852 Halley Terr. S.E. Wash. D.C.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis
DUE TO (b): Hypertensive Cardio Vascular Disease 5 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 15 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June, 1960 to Feb 21, 1962 that (I) (we) last saw the deceased alive on Feb 21, 1962 and that death occured at 8:50 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Norman Donat Comeau

M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/21/62

22c. PHYSICIAN'S NAME (Type): Norman Donat Comeau

22d. ADDRESS: 3503 Penny St Mt Rainier Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/24/62

23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln

23d. LOCATION (City, town or county) (State): Colmar Manor, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Halley's Funeral Home Inc.

ADDRESS: Mt. Rainier Maryland

25a. REC'D BY REGISTRAR DATE: SEP 28 '62

25b. REGISTRAR'S SIGNATURE: Clifton E. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02266 02250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1. **PLACE OF DEATH**
a. COUNTY: Prince Georges
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenn Dale (rural)
c. LENGTH OF STAY IN 1b: MARYLAND — 1 yr., 4 mo., & 12 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Glenn Dale Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: D. C.
b. COUNTY: -
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1509 N. Capitol St., N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Albert; Middle: -; Last: Marbury

4. **DATE OF DEATH**: Month: 2; Day: 4; Year: 19 62

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ Separated
8. DATE OF BIRTH: 10/16/1893
9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months: - Days: -
IF UNDER 24 HRS.: Hours: - Min: -

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown
10b. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (County & State, or foreign country): Unknown
12. CITIZEN OF WHAT COUNTRY? -

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No
16. SOCIAL SECURITY NO.: -
17. INFORMANT: Unknown — Address: Decedent

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive encephalomalacia, frontal parietal lobes, (left)
DUE TO (b): Atherosclerotic occlusion of left middle cerebral artery
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: unknown

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypertensive heart disease; renal disease, left, probably pyelonephritis; hypostatic bronchopneumonia

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ HOMICIDE ☐ SUICIDE ☐ WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 9/23/ 2:15 19 60 to 2/4/ , 19 62 that (I) (we) last saw the deceased alive on 2/4/ 19 62, and that death occured at 2:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Moe Weiss M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
22b. DATE SIGNED: 2/4/1962
22c. PHYSICIAN'S NAME (Type): Moe Weiss, M.D.
22d. ADDRESS: Glenn Dale Hospital Glenn Dale, Md.

23a. BURIAL CREMATION REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/6/62
23c. NAME OF CEMETERY OR CREMATORY: Harmony Memorial Park
23d. LOCATION (City, town or county) (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Jas. Rattray
ADDRESS: 1700 Vermont Ave. Dist. Hgts. Md.
25a. RECD BY REGISTRAR DATE: FEB 13 62
25b. REGISTRAR'S SIGNATURE: John H. Whitson

Item 16 Film 308 3-16

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02267 02251

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in the funeral director, page 3 should be detached for use as the burial-transit permit. These sheets remove carbon papers. Pages 1 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANDREWS AIR FORCE BASE
c. LENGTH OF STAY IN 1b: MARYLAND 15 HRS 37 MIN
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): US AIR FORCE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GLASSMANOR
d. STREET ADDRESS: 4904 NEPTUNE AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO XX

3. NAME OF DECEASED (Type or print): First MARIA Middle CARILA Last MASLOG

4. DATE OF DEATH: Month FEBRUARY Day 19 Year 1962

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED [X] WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 18 FEBRUARY 1962

9. AGE (In years last birthday): yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours 15 Min. 37

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (County & State or foreign country): PRINCE GEORGES, MARYLAND

12. CITIZEN OF WHAT COUNTRY? UNITED STATES

13. FATHER'S NAME: VINCENTE MASLOG

14. MOTHER'S MAIDEN NAME: EVELYN E LEMAY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unkown) NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO: NONE

17. INFORMANT: MEDICAL RECORDS

Address: SAME AS ITEM #1

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Primary atelectasis
DUE TO (b): Cardiac Resp. Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Hypoxia & Anoxia

INTERVAL BETWEEN ONSET AND DEATH: 2011 hrs 18 Feb 62 → 1138 hrs 19 Feb 62 15'27"

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES XX NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a.m. p.m. Month Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from 10 11 PM 19 Feb, 19 62 to 1138 AM 19 Feb., 19 62, that (I) ~~(we)~~ last saw the deceased alive on.... 19 Feb 19 62., and that death occured at 1138 A M, from the causes and on the date stated above

22a. SIGNATURE: Westley D. Stepp

22b. DATE SIGNED: 19 Feb 62

22c. PHYSICIAN'S NAME (Type): Stepp Westley D. Capt USAF MC

M.D. ATTENDING PHYS. [X] MED DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: USAF Hosp Andrews AFB Md

23a. BURIAL CREMATION REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 2-23-62

23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l Cem

23d. LOCATION (City, town or county): Ft Myer (State) Va.

24. FUNERAL DIRECTOR'S SIGNATURE: W.W. Chambers Co

ADDRESS: 517-11th St SE Wash D C

25a. REC'D BY REGISTRAR DATE: FEB 23 '62

25b. REGISTRAR'S SIGNATURE: Ethel L. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02268 Reg. Dist No. 02252

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Madison Manner

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 556 Beacon Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FANNIE Middle Mc KINZIE Last
4. DATE OF DEATH: Month Feb. Day 4, Year 1962
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 21, 1870
9. AGE (In years last birthday): 91 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Thorpe
14. MOTHER'S MAIDEN NAME: Sarah Chadwell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
INFORMANT: Miss Lillian Mc Kinzie, Address 556 Beacon Road, Silver Spring, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia, Hypostatic — INTERVAL BETWEEN ONSET AND DEATH: 9 days
DUE TO (b): arteriosclerotic Heart Disease — 10 yrs
DUE TO (c): Generalized arteriosclerosis — 10 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senility with senile agitation.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED White at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/28, 1961, to 2/4, 1962 that I last saw the deceased alive on 2/3, 1962, and that death occurred at 3:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Harold F. McCann M.D. — ADDRESS (Street, city or town, state): 2355-16th St. N.W. — DATE SIGNED: 2/4/62
PHYSICIAN'S NAME (Type): HAROLD F. McCANN — Washington, D. C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-7-62
22c. NAME OF CEMETERY OR CREMATORY: St. Johns
22d. LOCATION (City, town or county) (State): Ellicott City, Md

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: F. C. Higinbothom, Ellicott City, Md
24a. REC'D BY REGISTRAR DATE: FEB 6 '62
24b. REGISTRAR'S SIGNATURE: Arthur L. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02269 — 02253

1. **PLACE OF DEATH**
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CLINTON MD.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SOUTHERN MD. HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 CLINTON
d. STREET ADDRESS: THRIFT RD Box 312
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: LILLIAN — Middle: M. — Last: MCLEAREN
4. **DATE OF DEATH**: Month: 2 — Day: 23 — Year: 1962

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 18 1895
9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): ILLINOIS
12. CITIZEN OF WHAT COUNTRY? AMERICAN

13. FATHER'S NAME: UNKNOWN
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: HUSBAND — Address: THRIFT RD Box 312

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ACUTE PULMONARY EDEMA — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b): RHEUMATIC HEART DISEASE — 10 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): 411 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): NONE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): NONE
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from 1957 19 57 to 2 , 19 62, that (I) (—) last saw the deceased alive on 2/23 19 62 and that death occured at 8:12 P M, from the causes and on the date stated above.

22a. SIGNATURE: Charles F. Colao MD
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/23/62
22c. PHYSICIAN'S NAME (Type): CHARLES F. COLAO MD.
22d. ADDRESS: BRANCH AVE CLINTON MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Feb 26-62
23c. NAME OF CEMETERY OR CREMATORY: Washington National
23d. LOCATION (City, town or county) (State): Suitland, Md

24. FUNERAL DIRECTOR'S SIGNATURE: SIMMONS BROS.
ADDRESS: 1661-66th Hyatt Rd. S. Fl.
25a. REC'D BY REGISTRAR DATE: FEB 26 '62
25b. REGISTRAR'S SIGNATURE:

wash DC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02270

CERTIFICATE OF DEATH

02254

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: Prince George County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 14 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Naylor
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clarance — Middle: — Last: Middleton

4. DATE OF DEATH: Month: Feb., Day: 26, Year: 1962

5. SEX: Male

6. COLOR OR RACE: Color

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5/29/93

9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State or foreign country): Pr. George's Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Middleton

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mamie Jones — Address: Aquasco, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Massive Cerebral Hemorrhage

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Pulmonar Embolic
DUE TO (c): Arteriosclerosis Heart Diseases

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory street, off ca bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2-12, 1962, to 2-26, 19.62, that (I) (we) last saw the deceased alive on 2-26, 19.62, and that death occured at 11.45 M from the causes and on the date stated above.

22a. SIGNATURE: R. V. Sasscer M.D.

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Dr. Robert Sasscer

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22d. ADDRESS: R.F.D. Box 2150, Upper Marlboro, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/2/62

23c. NAME OF CEMETERY OR CREMATORY: Brooks Methodist

23d. LOCATION (City, town or county) (State): Nottingham, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: George H. Kelson — ADDRESS: Aquasco, Maryland

25a. REC'D BY REGISTRAR — DATE: Feb 27 1962

25b. REG.STRAR'S SIGNATURE

MAR 7 '62

1

FOR STATE HEALTH DEPT.

M

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02271 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 02255

1 PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution Residence before adm'ssion)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 29 Seat Pleasant
d. STREET ADDRESS: 604 72nd. Place
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Betty; Middle: May; Last: Miller

4. DATE OF DEATH: Month: February; Day: 12; Year: 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 8, 1930
9. AGE (In years last birthday): 31 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress
10b. KIND OF BUSINESS OR INDUSTRY: Food
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jenkins
14. MOTHER'S MAIDEN NAME: Viola Thomason

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT: Eugene Leroy Miller — Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 4-30-1 Coronary occlusion
DUE TO (b): Coronary artery disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II. of item 18)
20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.
EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED: 2/12/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/14/62
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or country): Arlington,
(State): Va.

23. FUNERAL DIRECTOR: Francis Gasch's Sons
ADDRESS: Hyattsville, Maryland

24a. REC'D BY REGISTRAR
DATE: FEB 13 '62
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02272 **CERTIFICATE OF DEATH** 02256

Items 25 Film G507 2/23/62 iwk

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1

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural Adelphi
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Paint branch Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Va
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington Va
d. STREET ADDRESS: 2604 Key Blvd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: Adelaide Middle: Ferman Last: Mills

4. DATE OF DEATH Month: 2 Day: 17 Year: 1962

5. SEX: F
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct 2 1888
9. AGE (In years last birthday): 73 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Amhst Va.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Clarence J Campbell
14. MOTHER'S MAIDEN NAME: Sarah Ferman Parr

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Nursing Home records. Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Congestive Heart Failure	2 [illegible]
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Arteriosclerotic Cardiovascular Disease	10 yrs
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 10 25 [illegible], 195[illegible] to 2 17, 1962 that (I) (we) last saw the deceased alive on 2 16, 1962, and that death occured at [illegible] M, from the causes and on the date stated above

22a. SIGNATURE: [illegible signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2 17 62
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS: 7717 Carroll Ave, Takoma Park [illegible]

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/20/62
23c. NAME OF CEMETERY OR CREMATORY: Green Hill Cem.
23d. LOCATION (City, town or county) (State): Buena Vista, Va.

24. FUNERAL DIRECTOR'S SIGNATURE: [illegible] Funeral Home, C. M. [illegible] ADDRESS: Arl. Va
25a. REC'D BY REGISTRAR DATE: FEB 20 62
25b. REGISTRAR'S SIGNATURE: [illegible signature]

VR A15 (4)
15M 9/60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 1- Film 307 2-1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02273 Item 3, Telephone Call 2/6/62 jml

CERTIFICATE OF DEATH

02257

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1 PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Landover
d. STREET ADDRESS: Route #1 Box 460
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First /Phoris/ Farrys; Middle; Last Morgal
4. DATE OF DEATH: Month February; Day 1; Year 19 62
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12-27-1870
9. AGE (In years last birthday): 91 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (County & State or foreign country): Waynesboro, Ga.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: John L. Morgal
14. MOTHER'S MAIDEN NAME: Anna Miller
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Joseph Elmer Morgal, Son Address: address above

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): C.H.F. (Chronic) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: Unknown
DUE TO (b): Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Generalized A.S.D, Premon C.V.A. Cerebral Vascular Accident — Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 2/1/62, 19.., to 2/1/62, 19....., that (I) (we) last saw the deceased alive on 2/1/62 19....., and that death occured at 3:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: R.V.G. Sasscer M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑
22b. DATE SIGNED: 3 Feb 62
22c. PHYSICIAN'S NAME (Type): Dr. Robert V.G. Sasscer
22d. ADDRESS: R.F.D. Box 2150, Upper Marlboro, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/5/62
23c. NAME OF CEMETERY OR CREMATORY: Washington National
23d. LOCATION (City, town or county) (State): Suitland, Md.
24 FUNERAL DIRECTOR'S SIGNATURE: Malley's Funeral Home Inc.
ADDRESS: Mt. Rainier Md.
25a. REC'D BY REGISTRAR DATE: FEB 6 '62
25b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02274

CERTIFICATE OF DEATH

02258

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANDREWS AIR FORCE BASE
c. LENGTH OF STAY IN this place
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): US AIR FORCE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: VIRGINIA
b. COUNTY: FAIRFAX
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNANDALE
d. STREET ADDRESS: 305 CHAPEL DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ARNOLD — Middle: — Last: MULLINS

4. DATE OF DEATH: Month: Feb — Day: 4 — Year: 1962

5. SEX: MALE

6. COLOR OR RACE: CAUCASIAN

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 29 OCTOBER 1922

9. AGE (In years last birthday): 39 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PILOT

10b. KIND OF BUSINESS OR INDUSTRY: US AIR FORCE

11. BIRTHPLACE (County & State or foreign country): MOSSY BOTTOM, KENTUCKY

12. CITIZEN OF WHAT COUNTRY? UNITED STATES

13. FATHER'S NAME: DOCK BILL MULLINS

14. MOTHER'S MAIDEN NAME: ALKA WELLS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES — (If yes give year or dates of service): 1942-Present

16. SOCIAL SECURITY NO: 406-12-4732

17. INFORMANT: PERSONNEL RECORDS — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): 860X MULTIPLE FRACTURES — INTERVAL BETWEEN ONSET AND DEATH: IMMEDIATE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): HEMOTHORAX — IMMEDIATE

DUE TO (c): PNEUMOTHORAX — IMMEDIATE

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): AIRPLANE CRASH

20c. TIME OF INJURY: Hour a.m. p.m. 2000 — Month, Day, Year: 4 Feb 62

20d. INJURY OCCURRED While at work ☒ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): FLIGHT LINE

20f. (City or town) ANDREWS AIR FORCE BASE, MD (County) (State)

21. I certify that (I) XXXXXXX attended the deceased from 4 February, 1962, to 4 February 19 62 that (I) XX last saw the deceased alive on 4 February 19 62, and that death occured at 840P.M., from the causes and on the date stated above.

22a. SIGNATURAL: Albert Carilli M.D.

ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 4 Feb 62

22c. PHYSICIAN'S NAME (Type): ALBERT D CARILLI, Capt USAF MC

22d. ADDRESS: USAF HOSPITAL, ANDREWS AIR FORCE BASE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 2/7/62

23c. NAME OF CEMETERY OR CREMATORY: ARL NAT CEM

23d. LOCATION (City, town or county): FORT MYER (State): VA

24. FUNERAL DIRECTOR'S SIGNATURAL: WW CHAMBERS CO

ADDRESS: 517-11th St SE WASH DC

25a. REC'D BY REGISTRAR DATE: FEB 9 '62

25b. REGISTRAR'S SIGNATURAL: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02275 **CERTIFICATE OF DEATH** 02259

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Piscataway
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ✓ Piscataway
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: MARY — Middle: L. — Last: MUNSON

4. **DATE OF DEATH**: Month: Feb. — Day: 9, — Year: 1962

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct 2, 1891

9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (City & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Francis Butler

14. MOTHER'S MAIDEN NAME: Elizabeth Newman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Thomas Munson, 8730 Old Ft. Rd., Wash, D.C.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): [illegible] — INTERVAL BETWEEN ONSET AND DEATH: 6 DAYS

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour: a.m. / p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb. 5th, 19 62 to Feb. 9th, 19 62, that (I) (we) last saw the deceased alive on Feb. 9th, 19 62, and that death occured at 3:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Paul Chen, M.D.

22b. DATE SIGNED: Feb. 9th, 1962

22c. PHYSICIAN'S NAME (Type): PAUL CHEN, M. D.

M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: ACCOKEEK, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2-13-62

23c. NAME OF CEMETERY OR CREMATORY: St Marys

23d. LOCATION (City, town or county) (State): Piscataway, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: The Huntt Funeral Home, Waldorf, Maryland

25a. REC'D BY REGISTRAR — DATE: FEB 14 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

1 2

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02276 02260

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15MD
5M 9 6D

M

1

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If last lut one Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brentwood
d. STREET ADDRESS: 4412 38th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry Middle: Francis Last: Nicholson

4. DATE OF DEATH: Month: February Day: 19 Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 7, 1878

9. AGE (In years last birthday): 83 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baker

10b. KIND OF BUSINESS OR INDUSTRY: Food

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Andrew J. Nicholson

14. MOTHER'S MAIDEN NAME: Fannie Bartlett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give wars or dates of service):

16. SOCIAL SECURITY NO.: 578-09-6781

17. INFORMANT: Robert Francis Nicholson, same as # 2 Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c).)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Acute congestive heart failure

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b): Cardiovascular renal disease

DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

DATE SIGNED: 2/19/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-22-62

22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cem.

22d. LOCATION (City, town, or country): Bladensburg, Md (State):

23. FUNERAL DIRECTOR: W. W. Chambers Co. ADDRESS: Riverdale, Md.

24a. REC'D BY REGISTRAR DATE: FEB 21 '62

24b. REGISTRAR'S SIGNATURE:

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02277 Item 8 Film G207 2/13/62 lwk

CERTIFICATE OF DEATH

02261

1. **PLACE OF DEATH**
a. COUNTY: Prince Geo. County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: one month
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Geo. Gen. Hosp.

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bladensburg
d. STREET ADDRESS: 1905 Taylor St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Percy — Middle: M. — Last: Norman

4. **DATE OF DEATH**: Month: 2 — Day: 3 — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-5-95// 1894

9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR, Months: — Days: — IF UNDER 24 HRS. Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Foreman

10b. KIND OF BUSINESS OR INDUSTRY: St. Elizabeth's Hospt.

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph H. Norman

14. MOTHER'S MAIDEN NAME: Sarah Marshall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, war or dates of service): WW1

16. SOCIAL SECURITY NO.:

17. INFORMANT: Virginia M. Norman same as #2 (Wife) — Address:

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 3 + 2 X — L Cerabral Abscess.
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐, OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1-4-62, 19.., to 2-3-62, 19.., that (I) (we) last saw the deceased alive on 2-3-62, 19.., and that death occured at 11:00 PM, from the causes and on the date stated above.

22a. SIGNATURE: R.B.G. Sasscer M.D.

22b. DATE SIGNED:

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): Dr. Robert B.G.Sasscer

22d. ADDRESS: R.F.D. Box 2150, Upper Marlboro, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/7/62

23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln

23d. LOCATION (City, town or county): Colmar Manor, (State): Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Francis Gasch's Sons — ADDRESS: Hyattsville, Maryland

25a. REC'D BY REGISTRAR DATE: FEB 8 '62

25b. REGISTRAR'S SIGNATURE: Milton L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02278

CERTIFICATE OF DEATH

02262

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7 61

1. PLACE OF DEATH
a. COUNTY: Prince Georges
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Suitland 23
c. LENGTH OF STAY IN 1b: 23 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suitland Nursing Home, Inc.

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hillcrest Heights 21
d. STREET ADDRESS: 5012-26th Ave., S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Norris Middle: Agnes Last: Norris
4. DATE OF DEATH: Month: 2/ Day: 18 / Year: 1962
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10/24/1879
9. AGE (In years last birthday): 82 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): St. Mary's, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Frank Brown
14. MOTHER'S MAIDEN NAME: Thompson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Etta Weidman, 5012-26th Ave., Hillcrest Hgts. 21, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): 332 X — DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Cerebral Thrombosis — DUE TO
(c): Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH: (a) 3 yrs. (b) yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Surgical amputation rt. Lg. for arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1942 19.., to Feb. 18, 19.62 that (I) (we) last saw the deceased alive on 2/15/62 19..., and that death occured at 7 P.M. from the causes and on the date stated above.

22a. SIGNATURE: William H Martin
22b. DATE SIGNED: 2/19/62
22c. PHYSICIAN'S NAME (Type): WILBUR H. MARTIN M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22d. ADDRESS: 100 Williamsburg Pl. 3-5 md. 421 Constitution Ave. N.E. Wash. 2, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2-21-1962
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln
23d. LOCATION (City, town or county): Prince George County (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE: D. A. Willingly
ADDRESS: 131-11th St. S.E. Wash. DC
25a. REC'D BY REGISTRAR DATE: FEB 21 '62
25b. REGISTRAR'S SIGNATURE: L. Howes

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02279 **CERTIFICATE OF DEATH** 02263

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 15M 7-61

1. **PLACE OF DEATH**
   a. COUNTY: Prince Georges — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenn Dale (rural)
   c. LENGTH OF STAY IN 1b: 1 month and 11 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Glenn Dale Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If Inst tutional Residence before admission)
   a. STATE: D. C. — b. COUNTY: —
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
   d. STREET ADDRESS: 1230 N.H. Avenue
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: John — Middle: — Last: Oberleitner

4. **DATE OF DEATH**: Month: 2 — Day: 2 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 3/17/1887

9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months —, Days — — IF UNDER 24 HRS.: Hours —, Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waiter

10b. KIND OF BUSINESS OR INDUSTRY: Fred Buckholtz Occidental Restaurant

11. BIRTHPLACE (County & State, or foreign country): Austria

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Gus Oberleitner

14. MOTHER'S MAIDEN NAME: Elizabeth ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: decedent — Address: —

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchogenic Carcinoma, left lung, histological type undetermined.
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 6 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Post-irradiation fibrosis.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12/22/ 19 61 to 2/2/ , 19 62, that (I) (we) last saw the deceased alive on 2/2/ 19 62, and that death occured at 10:30 A.M., from the causes and on the date stated above

22a. SIGNATURE: [signature] M.D.

22b. DATE SIGNED: 2/2/62

ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): Moe Weiss, M.D.

22d. ADDRESS: Glenn Dale Hospital Glenn Dale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/6/62

23c. NAME OF CEMETERY OR CREMATORY: WASHINGTON NAT. CEM.

23d. LOCATION (City, town or county) (State): SUITLAND, MD.

24. FUNERAL DIRECTOR'S SIGNATURE: HYSONG F.H. ADDRESS: WASHINGTON, DC

25a. REC'D BY REGISTRAR: DATE 2/3/62

25b. REGISTRAR'S SIGNATURE: [signature]

Hysong Funeral Home 1300 N-St NW

F. H. Hysong-J. F. Hysong 1300 N-St NW Washington D.C.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02280

CERTIFICATE OF DEATH

02264

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mitchellville
c. LENGTH OF STAY IN 1b: 89 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R. F. D. Forest Place

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Mitchellville
d. STREET ADDRESS: R. F. D. Forest Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: NANNIE — Middle: (NMI) — Last: Peach

4. DATE OF DEATH: Month: Feb — Day: 23 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Nov. 13, 1872

9. AGE (In years last birthday): 89 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Dr. John Peach

14. MOTHER'S MAIDEN NAME: Bettie Wellford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT — Address: Mr. John W. Heim Same as #2 Nephew

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Arteriosclerosis - severe — DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — (b) — DUE TO — (c)

INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ — Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) — (County) — (State)

21. **I certify** that (I) (this hospital) attended the deceased from June, 1960, to 23 Feb, 1962, that (I) (we) last saw the deceased alive on 22 Feb, 1962, and that death occured at 10 A.M. from the causes and on the date stated above.

22a. SIGNATURE: R R Sasscer M D

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Robert Sasscer M. D.

ATTENDING PHYS. ☒ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22d. ADDRESS: Upper Marlboro, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/25/62

23c. NAME OF CEMETERY OR CREMATORY: Mt. Oak

23d. LOCATION (City, town or county): Mitchellville

(State): Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Francis Gasch's Sons

ADDRESS: Hyattsville, Maryland

25a. REC'D BY REGISTRAR — DATE: FEB 26 '62

25b. REGISTRAR'S SIGNATURE: Julius L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02231 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 02265

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

1. **PLACE OF DEATH**
   a. COUNTY: Prince George's — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
   c. LENGTH OF STAY IN 1b: D.O.A.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Prince George's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Landover Hills
   d. STREET ADDRESS: 4235 71st., Avenue
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF** (Type or print): First: Hattie — Middle: Elmyra — Last: Pearson

4. **DATE OF DEATH**: Month: February — Day: 12, — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: February 25, 1883

9. AGE (In years last birthday): 78 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Vernon Taylor

14. MOTHER'S MAIDEN NAME: Martha

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: 574-28-7027

17. INFORMANT: Ellen Fort — Address: 7600 Spring Street East Columbia Pk. Landover Md

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia
DUE TO (b): Influenza
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): James I. Boyd JAMES I. BOYD, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town or county)

DATE SIGNED: 2/13/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-15-1962

22c. NAME OF CEMETERY OR CREMATORY: Mont Lincoln Cemetery

22d. LOCATION (City, town, or country) (State): Bladensburg, Maryland

23. FUNERAL DIRECTOR: W. W. Chambers Co.

ADDRESS: Riverdale, Maryland.

24a. REC'D BY REGISTRAR — DATE: FEB 19 '62

24b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02232 — 02266

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: MARYLAND 15 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address.): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): College Park
d. STREET ADDRESS: 5017 Geromino Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby Boy; Middle: ; Last: Pennell

4. DATE OF DEATH: Month: February; Day: 15; Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January 31, 1962

9. AGE (In years last birthday): — yrs. IF UNDER 1 YEAR: Months: ; Days: 15 IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ----------

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (County & State, or foreign country): Prince George's, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard I. Pennell

14. MOTHER'S MAIDEN NAME: Mary Lou Adams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mother

Address: Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Premature
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Icterus Neonatorum (Etiology to know)
DUE TO
(c): Terminal Gastrointestinal Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH: 2/3/62

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(c)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town, (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 1-31 ..., 1962, to 2-15 ..., 1962, that (I) (we) last saw the deceased alive on ... 2-15 ... 19 62, and that death occured 11:50 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Thomas A. Christensen M.D.

ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 2/15/62

22c. PHYSICIAN'S NAME (Type): Dr. Thomas A. Christensen

22d. ADDRESS: 6905 Baltimore Avenue, College Park, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/19/62

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City, town or county) (State): Arlington, Va.

24. FUNERAL DIRECTOR'S SIGNATURE: Hasche Funeral Home

ADDRESS: Hyattsville, Md.

25a. REC'D BY REGISTRAR: FEB 19 '62

25b. REGISTRAR'S SIGNATURE: Ivan S. Kraus

1-35162

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02283 02267

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN this place: 26 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cedar Heights
d. STREET ADDRESS: 6223 Lee Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Phynes; Middle: ; Last: Perry

4. DATE OF DEATH: Month: February; Day: 19; Year: 1962

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-9-97

9. AGE (In years last birthday): 65 yrs. IF UNDER 1 YEAR: Months: ; Days: IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Laundry

11. BIRTHPLACE (County & State, or foreign country): Wash. D C

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give wer or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Rosa Perry 6223 Lee Pl. Cedar Hgts

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary Edema

DUE TO: Uremia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO: Bilateral Hydronephrosis and Hydroureter

(c) Benign Prostatic Hypertrophy

INTERVAL BETWEEN ONSET AND DEATH: Days ; Months ; Months ; Months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-24, 1962 to 2-19, 1962, that (I) (we) last saw the deceased alive on 2-19, 19 62, and that death occured at 11:35 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Hano Gelmi M.D.

22b. DATE SIGNED

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): Dr. Ottavio Gelmi

22d. ADDRESS: 1801 Eye St., N. W. Washington, D. C.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: 2-23-62

23c. NAME OF CEMETERY OR CREMATORY: Nat Harmony

23d. LOCATION (City, town or county) (State): Highland Pk Md

24. FUNERAL DIRECTOR'S SIGNATURE: Henry S Washington & Son

ADDRESS: 4925 Benning Ave NE

25a. REC'D BY REGISTRAR DATE: FEB 26 '62

25b. REGISTRAR'S SIGNATURE: Emma L. Hinman

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-trans't permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02284

CERTIFICATE OF DEATH

Reg Dist. No. 02268

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bowie
c. LENGTH OF STAY IN 1b: 78 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R. F. D.

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bowie
d. STREET ADDRESS: 1 R. F. D.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mabel — Middle: ELIZABETH — Last: Phelps

4. DATE OF DEATH: Month: Feb — Day: 4 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 10, 1880

9. AGE (In years last birthday): 81 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Bureau of Eng.

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Goverment

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William Warren Phelps

14. MOTHER'S MAIDEN NAME: Capitola Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT: Address: 7125 Allison St. (brother)
Spencer W. Phelps Landover Hills, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion with cardiac myocardial degeneration — Minutes

DUE TO (b): Arteriosclerotic Coronary Disease — Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Generalized Arteriosclerosis — Years

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Influenza - 1 week 421X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan, 1957, to 2/4, 1962, that I last saw the deceased alive on 2/3, 1962, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: H. James Kurtz M.D. ADDRESS (Street, city or town, state): R.F.D. Hyattsville Md DATE SIGNED: 2/4/62

PHYSICIAN'S NAME (Type): H. James Kurtz

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/7/62

22c. NAME OF CEMETERY OR CREMATORY: Holy Trinity Church

22d. LOCATION (City, town, or county) (State): Collington, Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Francis Gasch's Sons Hyattsville, Md.

24a. REC'D BY REGISTRAR DATE: FEB 6 '62

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02285

CERTIFICATE OF DEATH

02269

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 25 Bradbury Heights
d. STREET ADDRESS: 5315 W Street
a. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF (Type or print): First: Howard — Middle: — Last: Phillips

4. DATE OF DEATH: Month: Feb — Day: 28 — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 21 Mar. 1879

9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: School teacher

11. BIRTHPLACE (County & State or foreign country): Carthage, New York.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Orin Phillips

14. MOTHER'S MAIDEN NAME: Julia Manchester

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes give war or dates of service): ----

16. SOCIAL SECURITY NO: none.

17. INFORMANT: Loren W. Parker

Address: 5315 W St., Bradbury Pk, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): (1) Renal failure (Uremia)
DUE TO (b): (2) Carcinoma of the prostate gld.
DUE TO (c): (3) Bilateral Hydronephrosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2-26, 1962, to 2-28, 19 62 that (I) (we) last saw the deceased alive on 2-28, 19 62, and that death occured at 2.45A M from the causes and on the date stated above.

22a. SIGNATURE: Harry N Carlton, M.D.

22b. DATE SIGNED

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): Dr. Harry N. Carlton

22d. ADDRESS: 940 25th Street, N. W., Washington, D. C.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: 3/2/62

23c. NAME OF CEMETERY OR CREMATORY: Hillside Cemetery,

23d. LOCATION (City, town or county) (State): Champion, New York.

24. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: W. W. Chambers Co., 517 11th St., S.E.

25a. REC'D BY REGISTRAR DATE: MAR 5 '62

25b. REGISTRAR'S SIGNATURE: S. Kinna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VII A15 (4)
M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 n... be retained by the hospital or attending physician.
TO FUNERAL D...CTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 ... 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02286 ~~Item 9-film-G-508 3/2/62 jwk~~ 02270

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Glenn Dale (rural)
c. LENGTH OF STAY IN 1b: 7 yrs., 4 months, and 13 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Glenn Dale Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY: -
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 800 Rhode Island Ave. NW
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) — First: Newton — Middle: W. — Last: Phillips

4. DATE OF DEATH — Month: 2 — Day: 17 — Year: 1962

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 5/7/03
9. AGE (In years last birthday): 58 yrs. — IF UNDER 1 YEAR: Months - Days - — IF UNDER 24 HRS.: Hours - Min. -

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stableman
10b. KIND OF BUSINESS OR INDUSTRY: Stewarts Riding School
11. BIRTHPLACE (County & State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Warren Phillips
14. MOTHER'S MAIDEN NAME: Ira Huff

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No —
16. SOCIAL SECURITY NO.: ? -14-4375
17. INFORMANT: Decedent — Address:

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction, acute with complete heart block — 4 days
4 2 ...
DUE TO (b) Thrombosis, right coronary artery — 4 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c) Atherosclerotic coronary artery disease — unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Far advanced, pulmonary tuberculosis; pulmonary edema; right pleural effusion

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 10/4/ 1954 to 2/17/ 1962 that (I) (we) last saw the deceased alive on 2/17/ 1962, and that death occured at 8:00 p.M, from the causes and on the date stated above

22a. SIGNATURE: Moe Weiss M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
22b. DATE SIGNED: 2/17/1962
22c. PHYSICIAN'S NAME (Type): Moe Weiss, M.D.
22d. ADDRESS: Glenn Dale Hospital, Glenn Dale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2-24-62
23c. NAME OF CEMETERY OR CREMATORY: Amissville
23d. LOCATION (City, town or county) (State): Amissville, Va.

24. FUNERAL DIRECTOR'S SIGNATURE: Henry W. Joynes — ADDRESS: Warrenton, Va.
25a. REC'D BY REGISTRAR: DATE FEB 26 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

VR A15 4
15M 7 61

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02287 Reg. Dist. No. 02271

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Forestville
c. LENGTH OF STAY IN 1b: 3 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 4008 - 52nd Ave.

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Forestville
d. STREET ADDRESS: 4008 - 52nd Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Frances — Last: PLOTT
4. DATE OF DEATH: Month: 2 — Day: 7 — Year: 1962

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: MAR 18, 1885
9. AGE (In years last birthday): 77 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Rhode Island
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James T. Skuce
14. MOTHER'S MAIDEN NAME: Mary L Pierce

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: None
17. INFORMANT: Ina Sweeney — Address: 4005-52nd Ave Forestville Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chest Metastasis — INTERVAL BETWEEN ONSET AND DEATH: 3 Months
DUE TO (b): Recurrence of breast — 6 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic Cardiovascular Disease
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from April 20, 19 62, to Feb. 7, 19 62, that I last saw the deceased alive on Feb. 4, 19 62, and that death occurred at 10 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Peter Dilli M.D. — ADDRESS (Street, city or town, state): 6124 Central Ave. Capitol Heights Md — DATE SIGNED: 2-7-62

PHYSICIAN'S NAME (Type): PETER DILLI

22a. BUR A., CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 2-12-62
22c. NAME OF CEMETERY OR CREMATORY: Arlington Natl
22d. LOCATION (City, town, or county) (State): Arlington Va

23 FUNERAL DIRECTOR'S SIGNATURE: Semmes Bro. — ADDRESS: 1641 Good Hope Rd SE Wash 20 D.C.
24a. REC'D BY REGISTRAR DATE: FEB 9 '62
24b REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be [illegible] for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02288 02272

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Prince George's — MARYLAND; b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Maryland Park; c. LENGTH OF STAY IN 1b: 40 year; d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 6512 C Street

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) — a. STATE: Maryland; b. COUNTY: Prince George's; c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Maryland Park 20; d. STREET ADDRESS: 6512 C Street; e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sarah; Middle: Augusta; Last: Pohl

4. DATE OF DEATH: Month: Feb; Day: 7; Year: 19 62

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug 22, 1889

9. AGE (In years last birthday): 72 yrs.

IF UNDER 1 YEAR: Months / Days

IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.C.

13. FATHER'S NAME: John Cuff

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mr. Harry Francis Pohl, same as 7

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Cardiovascular renal disease

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: James J. Boyd M.D.

EXAMINER'S NAME (Type): JAMES J. BOYD

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

DATE SIGNED: 2-7-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-10-1962

22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln

22d. LOCATION (City, town, or country): Bladensburg (State): Md.

23. FUNERAL DIRECTOR — ADDRESS: Lee Funeral Home - Wash. 2, DC

24a. REC'D BY REGISTRAR — DATE: FEB 13 '62

24b. REGISTRAR'S SIGNATURE:

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02289

CERTIFICATE OF DEATH

Reg. Dist. No. 02273

1 PLACE OF DEATH
a. COUNTY PRINCE GEORGES MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MADISON MANOR NURSING HOME

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE Maryland b. COUNTY Pro George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) H Brentwood, Md
d. STREET ADDRESS 4420-39 st
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First ANTON Middle FREDERICK Last POHLMAN

4. DATE OF DEATH Month Feb Day 6 Year 1962

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Aug 4 - 1888
9. AGE (In years last birthday) 73 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY W.C. transit
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Henry Pohlmann
14. MOTHER'S MAIDEN NAME Emelia Meyer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Melvin E. Pohlmann Address Brentwood Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC FAILURE — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE — ?
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from — 19— to FEB 6 1962 that I last saw the deceased alive on — 19—, and that death occurred at 1 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE Howard D. Cohn MD
ADDRESS (Street, city or town, state) 6600 Bellcrest Rd W Hyattsville Md
DATE SIGNED 2/9/62
PHYSICIAN'S NAME (Type) HOWARD D. COHN West Hyattsville Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Feb 9, 1962
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery
22d. LOCATION (City, town, or county) Baltimore, Md. (State)

23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.
24a. REC'D BY REGISTRAR DATE FEB 9 '62
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02290

CERTIFICATE OF DEATH

02274

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN MARYLAND: 2 Hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oxen Hill
d. STREET ADDRESS: 2409 Oxen Run Apt. S
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mary; Middle: A.; Last: Polk

4. DATE OF DEATH: Month: February; Day: 8; Year: 19 62

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-15-22

9. AGE (In years last birthday): 40 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel McCarthy

14. MOTHER'S MAIDEN NAME: Mary (Last name unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give veteran's dates of service): No

16. SOCIAL SECURITY NO.: 579-22-1999

17. INFORMANT: Douglas T. Polk,
Address:

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2-8, 1962 to 2-8, 1962, that (I) (we) last saw the deceased alive on 2-8 19 62 and that death occured at 1.40, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR P.M. ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS: P. G. G. Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2-12-62

23c. NAME OF CEMETERY OR CREMATORY: Columbia Gardens Cem.

23d. LOCATION (City, town or county): Arlington, Va. (State)

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Ives Funeral Home, 2847 Wilson Blvd. Arl., Va.
By: C. M. Ives

25a. REC'D BY REGISTRAR DATE FEB 13 '62

25b. REGISTRAR'S SIGNATURE: [signature]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02291

CERTIFICATE OF DEATH

02275

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Prince Georges
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 24 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): College Park
d. STREET ADDRESS: 9604 49th Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles; Middle: Kelly; Last: Powell

4. DATE OF DEATH: Month: Feb; Day: 10; Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8 July 1891

9. AGE (In years last birthday): 70 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machanic

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Goverment

11. BIRTHPLACE (County & State or foreign country): Missouri

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: C. C. Powell

14. MOTHER'S MAIDEN NAME: Anna Steck

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unkown) (If yes give wear or dates of service): no

16. SOCIAL SECURITY NO.: 085-10-2361

17. INFORMANT: Miss Verda Powell
119 Willoughby Road
Fanwood, N. J.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intra cerebral Hemorrhage
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I,(a): Gastric ulcer

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 17 Jan ....., 1962, to 10 Feb ....., 19 62 that (I) (we) last saw the deceased alive on 10 Feb 1962 19 .., and that death occured at 12.50 A.M. the causes and on the date stated above.

22a. SIGNATURE: William B Gunther M.D.

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Dr. William B Gunther ., M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: 9812 49th Ave
College Park., Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 2/13/62

23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln

23d. LOCATION (City, town or county): Colmar Manor, (State) Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Hyattsville Funeral home ADDRESS: Maryland

25a. REC'D BY REGISTRAR DATE: FEB 14 '62

25b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02292 Item 8 Film G302 3/6/62 mh 02276

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hosp.

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: ~~Laurel~~ Maryland — b. COUNTY: P.G.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Laurel
d. STREET ADDRESS: General Delivery
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth — Middle: — Last: Powell
4. DATE OF DEATH: Month: 2 — Day: 27 — Year: 1962
5. SEX: F
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7/3/1895
9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Anne Arundel Co. Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Daniel Thomas
14. MOTHER'S MAIDEN NAME: Sarah Williams
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: William Powell
Address: Laurel R.F.D.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Congestive Heart Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Arteriosclerotic C.V.D.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. City or town — (County) — (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2-26, 1962, to 2-27, 1962, that (I) (we) last saw the deceased alive on 2-27, 19 62, and that death occured at 9:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Jeanne C Bateman M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Dr. Jeanne C. Bateman
22d. ADDRESS: 940-254 N. Kent St.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 3/3/62
23c. NAME OF CEMETERY OR CREMATORY: Bacons Chapel — 23d. LOCATION (City, town or county): Anne Arundel Co. — (State) Md
24. FUNERAL DIRECTOR'S SIGNATURE: Ridgley Lobby — ADDRESS: 502 - 4th St, Laurel
25a. REC'D BY REGISTRAR DATE MAR 2 '62 — 25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

M

I

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02298 02277

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Upper Marlboro
d. STREET ADDRESS: RFD 1653
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Carolyn — Middle — Last Ravenell

4. DATE OF DEATH: Month February — Day 3 — Year 19 62

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 8, 1953

9. AGE (In years last birthday): 8 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): District of Columbia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Juanita Ravenell

14. MOTHER'S MAIDEN NAME: James Edward Quarles

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs Mary Mitchell
Address: D.C. Welfare Departm Washington, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1491X

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): James I. Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED: February 3, 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-9-1962

22c. NAME OF CEMETERY OR CREMATORY: Harmony Memorial Park

22d. LOCATION (City, town, or country) (State): Huntsville, Md.

23. FUNERAL DIRECTOR: MALVAN & SCOTEY, INC.
ADDRESS: 424"R" St., N. W.

24a. REC'D BY REGISTRAR DATE: FEB 9 '62

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

Item 18 Film 514 6 4

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02294

CERTIFICATE OF DEATH

02278

M

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANDREWS AIR FORCE BASE
c. LENGTH OF STAY IN 1b: 3 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): US AIR FORCE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMP SPRINGS
d. STREET ADDRESS: 6402 LANHAM WAY
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOSEPH; Middle IRVING; Last REYNOLDS

4. DATE OF DEATH: Month FEBRUARY; Day 5; Year 1962

5. SEX: MALE

6. COLOR OR RACE: CAUCASIAN

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1 FEBRUARY 1962

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months; Days 3 — IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (County & State or foreign country): PRINCE GEORGES, MARYLAND

12. CITIZEN OF WHAT COUNTRY? UNITED STATES

I

13. FATHER'S NAME: WILLIAM ROBERT REYNOLDS

14. MOTHER'S MAIDEN NAME: ELEANOR ROSE DEANGELIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO: NONE

17. INFORMANT: MEDICAL RECORDS — Address: SAME AS ITEM #1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 771
DUE TO (b): Respiratory Distress Syndrome
DUE TO (c): Placental dysfunction
Hemorrhagic disease of newborn

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 75 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour; a.m. p.m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ~~I~~ (this hospital) attended the deceased from 1 Feb 1962 to 5 Feb 1962, that (I) (~~he~~) last saw the deceased alive on 5 Feb 1962, and that death occured at 0004 AM from the causes and on the date stated above.

22a. SIGNATURE: John A Moore M.D.

ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 5 Feb 62

22c. PHYSICIAN'S NAME (Type): JOHN A MOORE, Major USAF MC

22d. ADDRESS: USAF HOSPITAL, ANDREWS AIR FORCE BASE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 2/8/62

23c. NAME OF CEMETERY OR CREMATORY: ARL NATIONAL

23d. LOCATION (City, town or county) (State): FORT MYER VA

24. FUNERAL DIRECTOR'S SIGNATURE: W.W. CHAMBERS Co

ADDRESS: 517-11th St WASH DC

25a. REC'D BY REGISTRAR DATE: FEB 9 '62

25b. REGISTRAR'S SIGNATURE: Carthon L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

2 1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02295 02273

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15M9
5M 9 60

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oxon Hill
c. LENGTH OF STAY IN 1b: 2½ years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4955 White Oak Drive

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oxon Hill
d. STREET ADDRESS: 4955 White Oak ~~XXXX~~ Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sallye — Middle: Irvin — Last: Rogers

4. DATE OF DEATH: Month: February — Day: 16 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: December 15/04

9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Noah B. Austin

14. MOTHER'S MAIDEN NAME: Pearl Norsinger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.

17. INFORMANT: George Milton Rogers, same as # 2
Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Cardiovascular renal disease
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from. Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

SIGNATURE: James I Boyd M.D.
NAME (Type): James I. Boyd
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: February 17,1962
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 19-62
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln
22d. LOCATION (City, town, or county): Bladensburg (State): Md

23. FUNERAL DIRECTOR: Simmons Bro.
ADDRESS: 1661 Good Hope Rd S.E. Wash 20 D.C.

24a. REC'D BY REGISTRAR DATE: FEB 19 '62
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02296 02280

1 PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural — Forestville
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Forestville Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of — b. COUNTY: Columbia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 3359 Nichols Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3 NAME OF DECEASED (Type or print): First: Elsie — Middle: Oega — Last: RUSH

4. DATE OF DEATH: Month: February — Day: 8, — Year: 1962

5 SEX: Female — 6 COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ — 8 DATE OF BIRTH: September 28 1891 — 9 AGE (In years last birthday): 70 yrs — IF UNDER 1 YEAR: Months ___ Days ___ — IF UNDER 24 HRS: Hours ___ Min ___

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Keeper — 10b KIND OF BUSINESS OR INDUSTRY: (in Cleveland, Ohio) — 11. BIRTHPLACE (State or foreign country): West Virginia — 12 CITIZEN OF WHAT COUNTRY?: U.S. of A.

13. FATHER'S NAME: Lee Calvert — 14 MOTHER'S MAIDEN NAME: Samantha Cain

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service) — 16 SOCIAL SECURITY NO: 234-09-1659 — 17 INFORMANT: Mrs. Mary C. HUDSON — Address: 3359 Nichols Ave, Washington, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last — DUE TO (b): — DUE TO (c): — H91X
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic Heart Disease — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21 I certify that (I) (~~this hospital~~) attended the deceased from Feb. 6, 1962, to Feb. 8, 1962 that (I) (~~we~~) last saw the deceased alive on Feb. 8, 1962 and that death occurred at 9:15 P.M. from the causes and on the date stated above

22a SIGNATURE: Walcutt W. Gibson M.D. — ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐ — 22b DATE SIGNED: February 8, 1962
22c. PHYSICIAN'S NAME (Type): Walcutt W. Gibson, M.D — 22d ADDRESS: 4340 St. Barnabas Road, Washington 21, D.C.

23a BURIAL CREMATION REMOVAL (Specify): Burial — 23b DATE THEREOF: 2-12-1962 — 23c NAME OF CEMETERY OR CREMATORY: ROBERTS RIDGE CEMETERY — 23d LOCATION (City, town, or county) (State): MOUNDSVILLE, W. VIRGINIA

24 FUNERAL DIRECTOR'S SIGNATURE & ADDRESS: W. W. Chambers Co. Ruralo, Maryland — 25a RECEIVED BY REGISTRAR DATE: FEB 13 '62 — 25b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 15M 9/59

1

FOR STATE HEALTH DEPT.

M

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02297 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02281

1. PLACE OF DEATH
a. COUNTY: Prince Georges County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): District Heights
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): District Heights Medical Center

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): District Heights
d. STREET ADDRESS: 7702 District Heights Parkway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HENRY Middle SHARDEN Last SCHWAMP

4. DATE OF DEATH: Month February Day 7, Year 19 62.

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 15, 1961

9. AGE (In years last birthday): yrs. IF UNDER 1 YEAR: Months 7, Days; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10b. KIND OF BUSINESS OR INDUSTRY: Child

11. BIRTHPLACE (State or foreign country): Cheverly, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Sharden H. Schwamp

14. MOTHER'S MAIDEN NAME: Joanne Pritickies

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Sharden H. Schwamp, Address 7702 District Hgts.Parkway, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Measles
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1a

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a.m. p.m. Month Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from, Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I Boyd M.D.

EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town or county)

DATE SIGNED: February 7, 1962.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb.10,1962

22c. NAME OF CEMETERY OR CREMATORY: Washington National

22d. LOCATION (City, town, or country) (State): Suitland, Maryland

23. FUNERAL DIRECTOR: W. W. CHAMBERS CO.

ADDRESS: Riverdale, Md.

24a. REC'D BY REGISTRAR: DATE FEB 9 '62

24b. REGISTRAR'S SIGNATURE: Catherine L. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director as 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME SM 9'60

207181161

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02298 02282

1 PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
c. LENGTH OF STAY IN 1b: 8 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 4714 Oliver Street

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mary land
b. COUNTY: Pr. Geo,
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (5 Riverdale
d. STREET ADDRESS: 4714 Oliver Streei
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALEXANDER Middle B. Last SECOR
4. DATE OF DEATH: Month Feb. Day 8 Year 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12/2/78
9. AGE (In years last birthday): 83 yrs
IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Clerk Govt.
10b KIND OF BUSINESS OR INDUSTRY: Navy Dept.
11. BIRTHPLACE (State or foreign country): New York
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: J. Eugene Secor
14 MOTHER'S MAIDEN NAME: Maria Kenny

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown, if yes, give war or dates of service): No
16 SOCIAL SECURITY NO: 220347962A
17 INFORMANT: Elsie L. Secor — Address: Same as # 2 (Wife)

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): 4-20-62 Ac Pokumary Congestion.
DUE TO (b): Arteio-sclerotic Heart Disease
DUE TO (c): a decompensation

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH: 30 MTN

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 1956 19 to Feb 1962, that (I) (we) last saw the deceased alive on 2/11 1962, and that death occurred at 3:20 M, from the causes and on the date stated above

22a SIGNATURE: W. L. Etienne M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 2-8-62
22c PHYSICIAN'S NAME (Type): W. L. ETIENNE
22d ADDRESS: 4713 Berwyn Rd College Park, Md

23a BURIAL, CREMATION, REMOVAL (Specify): Removal & Burial
23b DATE THEREOF: 2/12/62
23c NAME OF CEMETERY OR CREMATORY: Riverview Cemetery
23d LOCATION (City, town, or county) (State): Port Ewen New York

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: F. Gasch's Sons Hyattsville, Md.
25a. REC'D BY REGISTRAR DATE: FEB 13 '62
25b REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A1S (4) 1SM 9/59

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02299 02283

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 9/60

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bowie
c. LENGTH OF STAY IN 1b: Few Hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in a hospital, give street address): Bowie Race Track

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE: Virginia
b. COUNTY: Stafford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Stafford
d. STREET ADDRESS: Route 1 Box 81
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ashton; Middle: ; Last: Shackelford

4. DATE OF DEATH: Month: February; Day: 13; Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: October 16, 1888

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Motorman

10b. KIND OF BUSINESS OR INDUSTRY: Streetcar

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Strother Alexander Shackelford

14. MOTHER'S MAIDEN NAME: Jeanette Mahoney N.W.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 578-10-7593

17. INFORMANT: Walter Gordon Shackelford, Wash. D.C.
Address: 1432 Girard St.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute CARDIAC FAILURE
DUE TO (b): SEVERE, OCCLUSIVE CORONARY ARTERIOSCLEROSIS
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James J. Boyd M.D.

EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town or county):

DATE SIGNED: 2/13/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-16-1962

22c. NAME OF CEMETERY OR CREMATORY: Ramath Ephraim

22d. LOCATION (City, town, or country): Stafford (State): Va

23. FUNERAL DIRECTOR: W. W. Chambers Co ADDRESS: Riverdale, Md.

24a. REC'D BY REGISTRAR DATE: FEB 19 '62

24b. REGISTRAR'S SIGNATURE: Charles S. Hinman

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by hospital or attending physician. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

02300

CERTIFICATE OF DEATH

02284

1. PLACE OF DEATH a. COUNTY: Prince George's MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Pro George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Landover Md — c. LENGTH OF STAY IN 1b:	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Landover Md
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 6600 Old Landover Road	d. STREET ADDRESS: 6600 Old Landover Road — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Suzie Middle: R Last: Shegogue	4. DATE OF DEATH Month: Feb Day: 2, Year: 1962

5. SEX: female	6. COLOR OR RACE: white	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: Oct 23, 1884	9. AGE (In years last birthday): 77 yrs — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: own Home	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: George M Henauld		14. MOTHER'S MAIDEN NAME: Annie Brooks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no	16. SOCIAL SECURITY NO: none	17. INFORMANT: Walter E Shegogue	Address: Landover, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Congestive heart Failure — 10 ? [illegible]

420.1

DUE TO (b): arteriosclerosis Coronary — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): arteriosclerosis generalized — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Large ventral hernia - fibroid uterus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month Day, Year 19 Hour a. m. p. m. — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1957 to Jan 7 1962 that (I) (we) last saw the deceased alive on 2-5 1962 and that death occurred at 3:30 AM, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED: 2-3-62

22c. PHYSICIAN'S NAME (Type): DAYTON C WATKINS — 22d. ADDRESS: 5318 Annapolis Rd Bladensburg Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: Feb 5, 1962	23c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cemetery	23d. LOCATION (City, town, or county) (State): Colmar Manor, Md.
24. FUNERAL DIRECTOR'S SIGNATURE: F. Gasch's Sons	ADDRESS: Hyattsville, Md.	25a. REC'D BY REGISTRAR DATE: Feb 7 '62	25b. REGISTRAR'S SIGNATURE: [signature]

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02301 **CERTIFICATE OF DEATH** 02285

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institutions: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edmonston
d. STREET ADDRESS: 5202 Decatur Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Mildred — Middle: A — Last: Shotland

4. **DATE OF DEATH**: Month: Feb — Day: 10 — Year: 19 62

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 21 June 1902

9. AGE (In years last birthday): 59 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Todd

14. MOTHER'S MAIDEN NAME: Gertrude E. Pratt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Gladys E. Landis — Address: 1226 Clagett Dr., College Park, Md. (Daughter)

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) COR-PULMONALE 443 X — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b) CHRONIC FIBROSIS WITH PULMONARY INSUFFICIENCY

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) HYPERTENSIVE CARDIOVASCULAR DISEASE

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb. 5, 1962 to Feb. 10, 1962, that (I) (we) last saw the deceased alive on 10 Feb 1962, 19..., and that death occured at 5.25 AM from the causes and on the date stated above.

22a. SIGNATURE: George Hageage M.D.

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Dr. George Hageage., M.D.

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: 3717 38th Street, Mt. Rainier., Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/12/62

23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln

23d. LOCATION (City, town or county) (State): Colmar Manor, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Hyattsville, Maryland — Davis Funeral Home

25a. REC'D BY REGISTRAR DATE FEB 13 '62

25b. REGISTRAR'S SIGNATURE: Owen L. Nuna

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02302

CERTIFICATE OF DEATH

036886

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly,
c. LENGTH OF STAY IN 1b: 33 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Upper Marlobofo, Md
d. STREET ADDRESS: Box 446
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Louise Marie — Middle — Last Showell

4. DATE OF DEATH: Month February — Day 22 — Year 19 62

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1/17/96

9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (City & State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: David Rudd

14. MOTHER'S MAIDEN NAME: Mary Anderson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): NO
(If yes give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Address Box 292 Q-
Mrs. Margaret Anderson-Rt 3-Easton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute pulomary edema - arteriosclerotic Ht. Disease
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Meningitis (organism undetermined)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July, 1961, to 22 Feb., 1962, that (I) (we) last saw the deceased alive on 22 Feb 1962, and that death occured at 8:30PM from the causes and on the date stated above.

22a. SIGNATURE: Robert B. G. Sassoer M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/22/62

22c. PHYSICIAN'S NAME (Type): Dr. Robert B. G. Sassoer

22d. ADDRESS: R.F.D. Box 2150, Upper Marlboro, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/25/62

23c. NAME OF CEMETERY OR CREMATORY: Trinity Newport Cem.

23d. LOCATION (City, town or county) (State): Newport Maryland.

24 FUNERAL DIRECTOR'S SIGNATURE: Ritchie Bros. Fun'l Home

ADDRESS: Upper Marlboro, Md.

25a. REC'D BY REGISTRAR DATE MR 9 '62

25b. REGISTRAR'S SIGNATURE: Charles L. Krauss

TO HOSPITAL CERTIFYING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02303

CERTIFICATE OF DEATH

Reg. Dist. No. 02286

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): W. Hyattsville
c. LENGTH OF STAY IN 1b: Four years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sacred Heart Home

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural — Rockville
d. STREET ADDRESS: 13611 Glen Mill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ellen — Middle: T. — Last: Simpson

4. DATE OF DEATH: Month: February — Day: 10 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 29, 1881

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: James Furlong

14. MOTHER'S MAIDEN NAME: Jane E. O'Keefe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO: None

17. INFORMANT: Sacred Heart Home — Address: Hyattsville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypostatic pneumonia
DUE TO (b): Chronic myocarditis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes. Arteriosclerosis.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 1956 to Feb. 10, 1962, that I last saw the deceased alive on 2/10, 1962, and that death occurred at 12:55 p.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward J. Parsons M.D. — ADDRESS (Street, city or town, state): 1746 K ST N.W. — DATE SIGNED: 2/14/62

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-13-1962

22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cem.

22d. LOCATION (City, town, or county) (State): Wash., D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: James T. Ryan, Inc. — ADDRESS: 317 Pa. Ave., SE.

24a. REC'D BY REGISTRAR DATE: FEB 13 '62

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be delivered with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02304 — 036888

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Prince George — STATE: MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 1 Hr 11 Min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George General

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
STATE: Maryland — b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 4913 78th Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby Boy — Middle: — Last: Singer

4. DATE OF DEATH: Month: Feb. — Day: 27 — Year: 1962

5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: Feb. 27, 1962

9. AGE (In years last birthday): yrs — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: 1 — Min.: 11

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None — 10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State or foreign country): Maryland — 12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Singer

14. MOTHER'S MAIDEN NAME: Virginia Rae Wineman Singer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mother — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 7522 — DUE TO (b): Complete Tot Obscured by Both Kidneys + ureters
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) — (County) — (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb. 27, 1962 to Feb. 27, 1962 that (I) (we) last saw the deceased alive on Feb. 27 1962, and that death occured at 4:55 P.M. the causes and on the date stated above.

22a. SIGNATURE: John P. Clum — M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 2-28-62

22c. PHYSICIAN'S NAME (Type): Dr. John P. Clum — 22d. ADDRESS: 6110 43rd Avenue, Hyattsville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation — 23b. DATE THEREOF: 3/10/62 — 23c. NAME OF CEMETERY OR CREMATORY: Prince Geo. Gen. Hospital — 23d. LOCATION (City, town or county) (State): Cheverly, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Harry W. Penn, Jr. — ADDRESS:

25a. REC'D BY REGISTRAR DATE: MAR 15 '62 — 25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02305

CERTIFICATE OF DEATH

Reg. Dist. No. 02287

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HILLSIDE
c. LENGTH OF STAY IN 1b: 25 YRS
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: 1108 - 57TH AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 26 HILLSIDE
d. STREET ADDRESS: 1108 - 57TH AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ETHEL Middle ELLSWORTH Last SMALL

4. DATE OF DEATH: Month FEB. Day 25TH Year 1962

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: Sept. 15, 1893

9. AGE (In years last birthday): 68 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RESTAURANT OPERATOR - SELF-EMPLOYED

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): WASHINGTON, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard L. Hunt

14. MOTHER'S MAIDEN NAME: Gertrude (?)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): NONE

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: ROBERT E. FRITZ Address: 1108-57TH AVE Hills

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO (b): Cerebral arteriosclerosis — 2 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): 331 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 1961 to Feb 25 1962 that I last saw the deceased alive on Feb 24, 1962, and that death occurred at 8:30 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Ernest E Cornelson M.D. ADDRESS (Street, city or town, state): 4400 Bowen Rise DATE SIGNED: 2/27/62

PHYSICIAN'S NAME (Type): ERNEST E CORNELSON WASHINGTON 19, DC

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: Feb. 28, 1962

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

22d. LOCATION (City, town, or county) (State): Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. CHAMBERS Co. ADDRESS: 517-11TH STS. WASH D.C.

24a. REC'D BY REGISTRAR DATE: FEB 28 '62

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

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2

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02306 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 02288

1 PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Seabrook
c. LENGTH OF STAY IN 1b: 1 year
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 9515 Sheridan Street

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Seabrook
d. STREET ADDRESS: 9515 Sheridan Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Shirley — Middle: Annette — Last: Smith

4 DATE OF DEATH: Month: February — Day: 26 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: November 14, 1934

9. AGE (In years last birthday): 27 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11 BIRTHPLACE (State or foreign country): District of Columbia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Leroy Jenkins

14. MOTHER'S MAIDEN NAME: Mable XXXX Reid

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)

16. SOCIAL SECURITY NO

17 INFORMANT — Address: Joseph Shiro Smith, same as # 2

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Insufficiency
DUE TO (b): Congenital defect of coronary Arteries
DUE TO (c): and occlusive Coronary Atherosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: James D. Boyd M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): James I. Boyd

Address (Street, city, town or county)

DATE SIGNED: 2/26/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/1/62

22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln

22d. LOCATION (City, town, or country) (State): Colmar Manor, Md.

23. FUNERAL DIRECTOR: Francis Gasch's Sons

ADDRESS: Hyattsville, Maryland

24a REC'D BY REGISTRAR — DATE: MAR 1 '62

24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME SM 9 60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02307

CERTIFICATE OF DEATH

02283

1. PLACE OF DEATH
a. COUNTY: Prince Georges
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Prince~~ Cheverly
c. LENGTH OF STAY IN Md: 29 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 30 Fairmont Heights
d. STREET ADDRESS: 902 - 60th. Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Wallace; Middle: E.; Last: Smith

4. DATE OF DEATH: Month: 2; Day: 15; Year: 1962

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-15-90

9. AGE (In years last birthday): 71 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: U.S Govt.

11. BIRTHPLACE (County & State, or foreign country): Va

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jack Smith

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Wallace Smith Jr. Address:

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Stomach & Metastases — INTERVAL BETWEEN ONSET AND DEATH: Unknown
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): 151

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-17-62 to 2-15-62, 19..., that (I) (we) last saw the deceased alive on 2-15-62, and that death occured at 6:30 A.M. P.M. the causes and on the date stated above.

22a. SIGNATURE: R B Sasscer M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): Dr. Robert B. G. Sassoer
22d. ADDRESS: R.F.D. Box 2150, Upper Marlboro, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2-19-62
23c. NAME OF CEMETERY OR CREMATORY: Carver Mem. Park
23d. LOCATION (City, town or county) (State): Murbrk Md

24. FUNERAL DIRECTOR'S SIGNATURE: H.S. Woodyard
ADDRESS: 4549 25 Denver
25a. REC'D BY REGISTRAR: FEB 20 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02308 **CERTIFICATE OF DEATH** 02290

Item 8 Film 6307 2/13/62 ink

1. PLACE OF DEATH
a. COUNTY: Prince Geo. County
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Geo. Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: PG
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
d. STREET ADDRESS: 320 Talbott Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elsie; Middle: V.; Last: Smithson

4. DATE OF DEATH: Month: 2; Day: 2; Year: 19 62

5. SEX: F

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 10-26-00

9. AGE (In years last birthday): 61 yrs. IF UNDER 1 YEAR: Months: ___ Days: ___ IF UNDER 24 HRS.: Hours: ___ Min: ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NURSE

10b. KIND OF BUSINESS OR INDUSTRY: NURSING

11. BIRTHPLACE (County & State, or foreign country): Pr. Geo. Co. Laurel, Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph F. Stevens

14. MOTHER'S MAIDEN NAME: Nettie M. Casthe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.

17. INFORMANT: Margaret Pierpont Address: Hyattsville Md.

(I)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 week

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b): Chronic Pyelonephritis — years

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchopneumonia, Arteriosllerotic Heart Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11-27-61 19 , to 2-2-62, 19 , that (I) (we) last saw the deceased alive on 2-2-62 19 , and that death occured at 8:50 PM from the causes and on the date stated above.

22a. SIGNATURE: C James Duke M.D

22b. DATE SIGNED: 2/3/62

22c. PHYSICIAN'S NAME (Type): Drs. Gelmi/Duke

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: 1801 Eye St., N. W., Wash., D.C. 6507 Riverdale Rd., Riverdale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/5/62

23c. NAME OF CEMETERY OR CREMATORY: East Lincoln Cem.

23d. LOCATION (City, town or county) (State): Colmar Manor, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: E Whitt Donaldson

ADDRESS: Laurel Md

25a. REC'D BY REGISTRAR DATE: FEB 8 62

25b. REGISTRAR'S SIGNATURE: Arthur L. Mause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02309 — Item 9 File G307 — 1/19/62 iwk — 02291

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/[illegible]

1. PLACE OF DEATH
a. COUNTY: Prince Geo. County
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Geo. Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: PG
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bowie
d. STREET ADDRESS: 12422 Stone Haven Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ETHEL, Middle L., Last SPENCER
4. DATE OF DEATH: Month 2-10-62, Day, Year 19
5. SEX: Female
6. [illegible]: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 6-5-1886
AGE (In years last birthday): 25 76
IF UNDER 1 YEAR: Months, Days
IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: own Home
11. BIRTHPLACE (City & State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John W Lovelace
14. MOTHER'S MAIDEN NAME: Henrietta C[illegible]ments

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.
17. INFORMANT: Irene Johnson — Address: Charlotte County Virginia

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic heart disease — Unknown
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic renal disease; Diabetes mellitus; Chronic cholecystitis;
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m., Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1/28, 1962 to 2/10, 1962 that (I) (we) last saw the deceased alive on 2/10, 1962, and that death occured at 1:45 p.m., from the causes and on the date stated above.

22a. SIGNATURE: Julius Kauffman, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/10/62
22c. PHYSICIAN'S NAME (Type): Julius Kauffman
22d. ADDRESS: 5102 Annapolis Rd., Bladensburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Feb 13, 1962
23c. NAME OF CEMETERY OR CREMATORY: Hebron Methodist
23d. LOCATION (City, town or county) (State): Charlotte County Va

24. FUNERAL DIRECTOR'S SIGNATURE: F. Gasch's Sons
ADDRESS: Hyattsville, Md.

25a. REC'D BY REGISTRAR DATE: FEB 13 '62
25b. REGISTRAR'S SIGNATURE: Curtiss L. Hines

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02310 **CERTIFICATE OF DEATH** 02292

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: Prince George's County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 1 hr. 55 min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Colmar Manor
d. STREET ADDRESS: 3814 - 42nd. St. 44-1
IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Sharon — Middle: LEE. — Last: Spencer

4. **DATE OF DEATH**: Month: February — Day: 23 — Year: 1962

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-19-62

9. AGE (In years last birthday): Yrs: 5 — IF UNDER 1 YEAR, IF UNDER 24 HRS.: Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (County & State, or foreign country): WASHINGTON, D.C

12. CITIZEN OF WHAT COUNTRY?: U S

13. FATHER'S NAME: James Spencer

14. MOTHER'S MAIDEN NAME: BARBARA ELLIOTT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: JAMES HERBERT SPENCER — Address: SAME AS #2

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Perforated Cecum — DUE TO (b): Meconium Ileus

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. City or town — (County) — (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2-23-62 to 2-23-62 that (I) (we) last saw the deceased alive on 2-23-1962, and that death occured at 7:10 A.M. from the causes and on the date stated above

22a. SIGNATURE: David S Clayman M.D.

ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 2/2/62

22c. PHYSICIAN'S NAME (Type): DAVID S CLAYMAN

22d. ADDRESS: 6311 Balto Ave - Riverdale. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 2-27-1962

23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem. — 23d. LOCATION (City, town or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: W D Chambers — ADDRESS: Riverdale Md

25a. REC'D BY REGISTRAR DATE: MAR 1 '62

25b. REGISTRAR'S SIGNATURE

1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02311 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 02293

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Prince George's — b. STATE: MARYLAND — b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel — c. LENGTH OF STAY IN 1b: D.O.A. — d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Laurel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) — a. STATE: Pennsylvania — b. COUNTY: Fulton — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Harrisonville — d. STREET ADDRESS: Star Route — e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Gertrude — Middle: Elizebeth — Last: sponsler

4. DATE OF DEATH: Month: February — Day: 22 — Year: 19 62

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: May 25, 1903

9. AGE (In years last birthday): 58 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Ellwood Leach

14. MOTHER'S MAIDEN NAME: Anna Rice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wer or dates of service): n.o.

16. SOCIAL SECURITY NO.: none

17. INFORMANT: 103 Tower Acres Dr Irene Julia Granata, Laural

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute pulmonary edema

DUE TO (b): Congestive heart failure

DUE TO (c): Coronary artery disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1.(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X] and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: James I. Boyd M.D

EXAMINER'S NAME (Type): James I. Boyd

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

DATE SIGNED: 2/22/62

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Feb 24, 1962 — 22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery — 22d. LOCATION (City, town, or country) (State): Altoona, Penn.

23. FUNERAL DIRECTOR — ADDRESS: De Witt Donaldson, Laurel, Md.

24a. RECD BY REGISTRAR DATE: FEB 26 '62

24b. REGISTRAR'S SIGNATURE: [illegible] S. Price

YS. A15ME
5M 9,60

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02312 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02294

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 9/60

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 37 Seat Pleasant
d. STREET ADDRESS: 606 64th Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Grace; Middle: Mildred; Last: Stanford

4. DATE OF DEATH: Month: February; Day: 14; Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 26, 1890

9. AGE (In years last b'thday): 71 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): District of Columbia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Eppley

14. MOTHER'S MAIDEN NAME: Margaret Mays

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Edwin Thomas Stanford Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute congestive heart failure
DUE TO (b): Cardiovascular renal disease
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒. Inquiry ☒. and in my opinion death resulted from: Natural causes ☒ Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED: 2/14/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/16/62

22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln

22d. LOCATION (City, town, or country, (State): Colmar Manor, Md.

23. FUNERAL DIRECTOR: Francis Gasch's Sons ADDRESS: Hyattsville, Md.

24a. REC'D BY REGISTRAR DATE: FEB 15 '62

24b. REGISTRAR'S SIGNATURE: [signature]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02313 Item 9 Film 0310 4/2 /62 mh

CERTIFICATE OF DEATH

02295

1. PLACE OF DEATH
a. COUNTY: Prince Georges
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN this place: 5 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Highland Park
d. STREET ADDRESS: 1210 69th Place.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth; Middle: ; Last: Taylor
4. DATE OF DEATH: Month: Feb; Day: 28; Year: 19 62
5. SEX: Female
6. COLOR OR RACE: Black
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 26 June 1923
9. AGE (In years last birthday): 39 38
IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS: Hours: ; Min.: —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State or foreign country): Elms City, N.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Walter Taylor
14. MOTHER'S MAIDEN NAME: Mary Boddie
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service) No
16. SOCIAL SECURITY NO: 219 10 6301
17. INFORMANT: Walter Taylor Address: 1210 69th Pl., Highland Pk, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple pul. emb.
DUE TO (b): Pul. edema
DUE TO (c): hyperthermatosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 105.4
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2-23 ..., 19 62 to 2-28 ..., 19 62 that (I) (we) last saw the deceased alive on 2-28 . 19 62 .., and that death occured at 12, 10AM from the causes and on the date stated above.

22a. SIGNATURE: Harry N Carlton, M D
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Dr. Harry N. Carlton
22d. ADDRESS: 940 25th Street, N.W., Washington, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-3-62
23c. NAME OF CEMETERY OR CREMATORY: Harmony
23d. LOCATION (City, town or county): Landover, (State) Md.
24. FUNERAL DIRECTOR'S SIGNATURE: Myrtle R Collins
ADDRESS: 4339 Hunt Pl. N.E.
25a. REC'D BY REGISTRAR DATE: MAY 5 '62
25b. REGISTRAR'S SIGNATURE: Lathan L. Hawes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02314

CERTIFICATE OF DEATH

02296

1

M

I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brentwood
d. STREET ADDRESS: 4010 Allison Street
IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Fenley; Middle: ; Last: Taylor

4. DATE OF DEATH: Month: February; Day: 23; Year: 1962

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED X ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 1-9-82

9. AGE (In years last birthday): 80 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State or foreign country): VA.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: FENLEY TAYLOR

14. MOTHER'S MAIDEN NAME: CATHERINE MASTERSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Hospital Record

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive heart failure

DUE TO (b): Myocardial Infarction secondary to occlusion of left anterior descending coronary artery

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Coronary Arteriosclerotic Heart Disease

INTERVAL BETWEEN ONSET AND DEATH: days / years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO X

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2-21, 19.62 to 2-23, 19.62, that (I) (we) last saw the deceased alive on 2-23 1962, and that death occured at 5:20 A.M. from the causes and on the date stated above.

22a. SIGNATURE: R B Sasscer M.D.

ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☑

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Dr. Robert B. G. Sasscer

22d. ADDRESS: R.F.D. Box 2150, Upper Marlboro, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 2.28.62

23c. NAME OF CEMETERY OR CREMATORY: WOODLAWN CEMETERY

23d. LOCATION (City, town or county) (State): WASHINGTON, D.C.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Robert L. McGuire 1820 9th St NW WASHINGTON, D.C.

25a. REC'D BY REGISTRAR DATE: FEB 28 '62

25b. REGISTRAR'S SIGNATURE: Thos. E. Kane

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02315

CERTIFICATE OF DEATH

02237

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 7/61

1. PLACE OF DEATH
a. COUNTY: Prince Georges
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenn Dale (rural)
c. LENGTH OF STAY IN MARYLAND: 7 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Glenn Dale Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a. STATE: D. C.
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 3416 Harder St., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles; Middle: Taylor; Last: Terry, Jr.

4. DATE OF DEATH: Month: 2; Day: 28; Year: 1962

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☒

8. DATE OF BIRTH: 1/3/1885

9. AGE (In years last birthday): 77 yrs. IF UNDER 1 YEAR, Months: — Days: — IF UNDER 24 HRS. Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired (unknown)

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (County & State, or foreign country): Mississippi

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles Terry, Sr.

14. MOTHER'S MAIDEN NAME: Mary Campbell Terry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Decedent
Address:

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Ruptured aneurysm, abdominal aorta — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO (b): Severe atherosclerosis — unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.: Pulmonary tuberculosis; intestinal malignancy, historical, type and site undetermined

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2/21/ 1962, to 2/28/ 1962, that (I) (we) last saw the deceased alive on 2/28/ 1962, and that death occured at A.M, from the causes and on the date stated above.

22a. SIGNATURE: Moe Weiss M.D

ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 2/28/62

22c. PHYSICIAN'S NAME (Type): Moe Weiss, M.D.

22d. ADDRESS: Glenn Dale Hospital, Glenn Dale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/3/62

23c. NAME OF CEMETERY OR CREMATORY: Carver Memorial Funeral

23d. LOCATION (City, town or county) (State): , Md

24. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden

ADDRESS: Rockville, Md

25a. REC'D BY REGISTRAR DATE: MAR 5 '62

25b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02316

CERTIFICATE OF DEATH

02298

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: MARYLAND 4 Hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Beltsville
d. STREET ADDRESS: 10622 Molcolgra Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: George; Middle: M.; Last: Thomas

4. DATE OF DEATH: Month: February; Day: 21; Year: 1962

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 20, 1881

9. AGE (In years last birthday): 80 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State or country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: George M. Thomas

14. MOTHER'S MAIDEN NAME: Angeline ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Olivia Gross: same as item 2: Address:

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): H20.C Pulmonary emphysema

DUE TO (b): Arteriosclerotic Heart disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2-21, 1962, to 2-21, 1962 that (I) (we) last saw the deceased alive on 2-21 19 62, and that death occured at 2:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Jeanne C Bateman M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/22/62

22c. PHYSICIAN'S NAME (Type): Jeanne C. Bateman, M. D.

22d. ADDRESS: 940 25th St, N.W., Washington 7, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/24/62

23c. NAME OF CEMETERY OR CREMATORY: Ash Memorial.,

23d. LOCATION (City, town or county) (State): Sandy Spring, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden ADDRESS: Rockville, Md.

25a. REC'D BY REGISTRAR DATE: FEB 28 '62

25b. REGISTRAR'S SIGNATURE: Cathryn L. [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02317

CERTIFICATE OF DEATH

02299

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Adelphi
c. LENGTH OF STAY IN 1b: 1 yr. 2 mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Twin Branch Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 4048 7th St., N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ethel — Middle: Vella — Last: Tompkins

4. DATE OF DEATH: Month: Feb. — Day: 15 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 23, 1882

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months: — Days:
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel S. Roberts

14. MOTHER'S MAIDEN NAME: Eliza Roberts

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO: none

17. INFORMANT: Address: Nursing home records

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lt. Lung X Senile type terminal pneumonia
DUE TO (b): hypertensive heart disease.
DUE TO (c): Generalized arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 4 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1.a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1962 Feb 10 to 19 62 Feb 15, that (I) (we) last saw the deceased alive on 15 Feb 19 62, and that death occured at 4:45 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Thomas E. Mattingly, M.D.
M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 15 Feb 62

22c. PHYSICIAN'S NAME (Type): Thomas E. Mattingly, M.D.
22d. ADDRESS: 2200 R.I. Ave N.E. 18 D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2-19-62
23c. NAME OF CEMETERY OR CREMATORY: Mt. Zion Baptist Cem.
23d. LOCATION (City, town or county) (State): Bethesda Md

24. FUNERAL DIRECTOR'S SIGNATURE: Deal Funeral Home
ADDRESS: 4812 Duke Md

25a. REC'D BY REGISTRAR DATE: FEB 19 '62
25b. REGISTRAR'S SIGNATURE

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02318 02305

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Greenbelt
d. STREET ADDRESS: 7 K Southway Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Agnes — Middle: Tillie — Last: Tonker

4. DATE OF DEATH: Month: February — Day: 6 — Year: 19 62

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: February 2, 1908

9. AGE (In years last birthday): 54 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Government Clerical

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Illnois

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Fred Richter

14. MOTHER'S MAIDEN NAME: Anna Cunat

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: 579-07-2871

17. INFORMANT: Mrs. Nancy M. Fox, 44B Ridge Road, Address Greenbelt, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemorrhage and shock
DUE TO (b): Massive retroperitonal hemorrhage
DUE TO (c): Fracture of the pelvis, fractures of ribs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: — — —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.): Passenger in an automobile that was in a collision

20c. TIME OF INJURY Month, Day, Year: Hour 2:30 XX p.m. 2/4/62, 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Road

20f. (City or town): Mitchellville (County): P.G. (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): James I. Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED: February 7, 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb. 10, 1962

22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery

22d. LOCATION (City, town, or country) (State): Bladensburg, Maryland.

23. FUNERAL DIRECTOR: W. W. CHAMBERS CO. — ADDRESS: Riverdale, Md.

24a. REC'D BY REGISTRAR DATE FEB 9 '62

24b. REGISTRAR'S SIGNATURE: Evelyn L. Kinna

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME 5M 9/60

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 9 60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02319 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 02301

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: MARYLAND 8 1/2 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Rainier
d. STREET ADDRESS: 4009 30th., Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James Middle: Edward Last: Trainor

4. DATE OF DEATH: Month: February Day: 10, Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: August Sept. 1, 1909

9. AGE (In years last birthday): 52 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic

10b. KIND OF BUSINESS OR INDUSTRY: Automobile

11. BIRTHPLACE (State or foreign country): CALVERT, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Alexander Trainor

14. MOTHER'S MAIDEN NAME: Helen Elizabeth England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 578-01-9160

17. INFORMANT: Joseph L. Trainor, Address: 9104 Providence Ave. Silver Springs, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

DATE SIGNED: 2/10/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-12-62

22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery

22d. LOCATION (City, town, or country) (State): Prince George's Co. Maryland

23. FUNERAL DIRECTOR: Raymond C. Zicka
Warner E. Pumphrey, Inc. ADDRESS 8434 Georgia Ave. Silver Spring, Md.

24a. REC'D BY REGISTRAR DATE: FEB 14 '62

24b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02320

CERTIFICATE OF DEATH

02302

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN: MARYLAND: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rogers Heights
d. STREET ADDRESS: 5603 Decatur Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Arthur; Middle: Emil; Last: Trost Jr.

4. DATE OF DEATH: Month: February; Day: 6; Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-4-03

9. AGE (In years. If under 1 year, last birthday): 58 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ceramic

10b. KIND OF BUSINESS OR INDUSTRY: Supplies

11. BIRTHPLACE (County & State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Arthur Emil Trost Sr.

14. MOTHER'S MAIDEN NAME: Lida Camp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no

16. SOCIAL SECURITY NO (If yes give war or dates of service):

17. INFORMANT: Josephine M. Trost same as #2 (Wife)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary infarction
DUE TO (b): Hypertensive Cardio-renal disease
DUE TO (c): Viral infection

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 2-3-62

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2-3 to 2-6, 1962, that (I) (we) last saw the deceased alive on 2-6, 1962, and that death occured at 11:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: George Hageage

22b. DATE SIGNED

M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): Dr. George J. Hageage

22d. ADDRESS: 3717 38th Avenue, Cottage City, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/10/62

23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet

23d. LOCATION (City, town or county): Washington D. C.

24 FUNERAL DIRECTOR'S SIGNATURE: Francis Gasch's Sons

ADDRESS: Hyattsville, Maryland

25a. REC'D BY REGISTRAR DATE: FEB 8 '62

25b. REGISTRAR'S SIGNATURE: Clinton L. Thomas

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02321

CERTIFICATE OF DEATH

Reg. Dist. No. 02303

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mitchellville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Enterprise Rd

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: P.G.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mitchellville
d. STREET ADDRESS: Enterprise Rd.
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Eva — Middle: Jane — Last: Waesche

4. DATE OF DEATH: Month: 2 — Day: 18 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb 26 1879

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Mitchellville Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward S Walker

14. MOTHER'S MAIDEN NAME: Sophronia Duckett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: 213-36-5425

INFORMANT: Sophronia M Hunt (Daughter)
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Intestinal Obstruction — INTERVAL BETWEEN ONSET AND DEATH: 9 days

1450

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b): Incarcerated Artery Thrombosis — 9days

DUE TO (c): Generalized Arteriosclerosis — yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic Aortic Aneurysm, Arteriosclerotic Heart Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month — Day — Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb, 19 57, to Feb 18, 1962, that I last saw the deceased alive on 2/17/62, 19, and that death occurred at 4:33 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James Kurtz M.D

ADDRESS (Street, city or town, State): RED Glenn Dale Md.

DATE SIGNED: 2/18/62

PHYSICIAN'S NAME (Type): H. James Kurtz

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 2-20-62

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill

22d. LOCATION (City, town, or county) (State): Suitland Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J Wm Lee & Sons — ADDRESS: 300 H St NE.

24a. REC'D BY REGISTRAR — DATE: FEB 21 '62

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

02322

CERTIFICATE OF DEATH

02304

1 PLACE OF DEATH
a. COUNTY: Pr. Geo. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
c. LENGTH OF STAY IN 1b: 2 Yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 5707 Jamestown Rd.

2. USUAL RESIDENCE (Where deceased lived — If institution, Residence before admission)
a. STATE: Md.
b. COUNTY: Pr. Geo.
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 5707 Jamestown Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: HERBERT Middle: R. Last: WELLS

4. DATE OF DEATH: Month: Feb. Day: 9 Year: 1962

5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 14 Mar 1896
9 AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cartographic Aid, Ret.
10b. KIND OF BUSINESS OR INDUSTRY: Army Map Serv.
11. BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James A. Wells
14. MOTHER'S MAIDEN NAME: Linda Rodamor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW 1
16 SOCIAL SECURITY NO: 172014639
17 INFORMANT: Adelaide W. Wells — Address: Same as # 2 (Wife)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Chronic Lymphatic Leucemia — INTERVAL BETWEEN ONSET AND DEATH: 2 months

DUE TO (b): with Thrombocytopenia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchiectasis

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 10-19, 1961, to 2-9, 1962, that (I) (we) last saw the deceased alive on 2-8, 1962, and that death occurred at 5 A M, from the causes and on the date stated above

22a SIGNATURE: Randolph Fleischer M.D.
ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 2-9-62
22c PHYSICIAN'S NAME (Type): RONALD S. FLEISCHER
22d ADDRESS: 905 SHERIDAN RD. HYATTSVILLE MD

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/12/62
23c NAME OF CEMETERY OR CREMATORY: Arl. Natl. Ceme.
23d LOCATION (City, town, or county) (State): Arlington Va.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: F. Gasch's Sons Hyattsville, Md.
25a REC'D BY REGISTRAR DATE: FEB 13 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02323

CERTIFICATE OF DEATH

02305

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH** a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel — c. LENGTH OF STAY IN this place: 14 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 379 Main Street

2. **USUAL RESIDENCE** (Where deceased lived, If institution, residence before admission)
a. STATE: Md — b. COUNTY: Pr. George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 01 Laurel
d. STREET ADDRESS: 379 Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Jane — Middle: Landis Wenzel — Last: —
4. **DATE OF DEATH**: Month: Feb — Day: 18 — Year: 1962
5. SEX: F — 6. COLOR OR RACE: W — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: Sept 10, 1888 — 9. AGE (In years last birthday): 73 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife — 10b. KIND OF BUSINESS OR INDUSTRY: House — 11. BIRTHPLACE (County & State, or foreign country): Camden, N. J. — 12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph Landis — 14. MOTHER'S MAIDEN NAME: Marie Eble

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wars or dates of service): not — 16. SOCIAL SECURITY NO. — 17. INFORMANT: George Wenzel — Address: 702 Mont St Laurel Md

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Congestive Myocardial Infarction
DUE TO (b): Generalized Arteriosclerosis
DUE TO (c): Arteriosclerotic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
420.5
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: 19 — 20d. INJURY OCCURRED: While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) — (County) — (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1959 to 1962, that (I) (~~was~~) last saw the deceased alive on January 15 1962, and that death occured at 4.30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Robert C. Winfield — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: Feb 18, 1962

22c. PHYSICIAN'S NAME (Type): ROBERT C. WINFIELD — 22d. ADDRESS: Laurel, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: Feb 21, 1962 — 23c. NAME OF CEMETERY OR CREMATORY: Carver Mem Park Muirkirk — 23d. LOCATION (City, town or county) (State): Md

24. FUNERAL DIRECTOR'S SIGNATURE: DeWitt Donaldson — ADDRESS: Laurel, Md — 25a. REC'D BY REGISTRAR DATE: FEB 26 '62 — 25b. REGISTRAR'S SIGNATURE

VR A15 (4) 15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02324 02306

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
d. STREET ADDRESS: 1704 Sandy Springs Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: E. — Last: Whaley

4. DATE OF DEATH: Month: Feb — Day: 26 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 16 July 1903

9. AGE (In years last birthday): 58 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Insurance Agent

10b. KIND OF BUSINESS OR INDUSTRY: Insurance

11. BIRTHPLACE (City & State or foreign country): Whitestone Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert Kent Whaley Sr

14. MOTHER'S MAIDEN NAME: Clara Belle Sanders

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.

17. INFORMANT: R. K. Whaley Jr., Whitestone, Va. — Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Sclerosis — DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): L'Annec's Cinnhosis of Liver — DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH: 3 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Emphysema of Lungs

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2/17/62, 19, to 2/26/62, 19, that (I) (~~we~~) last saw the deceased alive on 2/26, 1962, and that death occured at 9:40 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Norman Donat Comeau M.D.

ATTEND.NG PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/26/62

22c. PHYSICIAN'S NAME (Type): Norman Donat Comeau

22d. ADDRESS: 3503 Penny St Mt Rainier Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/1/62

23c. NAME OF CEMETERY OR CREMATORY: Union Cemetery

23d. LOCATION (City, town or county): Bustamville (State) Md

24. FUNERAL DIRECTOR'S SIGNATURE: DeWitt Donaldson — ADDRESS: Laurel Md

25a. REC'D BY REGISTRAR DATE: MAR 1 '62

25b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02325 — Item 9 Film G308 3/6/62 mh — 02307

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 27 D.C.
d. STREET ADDRESS: 6250 Rollins Ave. S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Agnes — Middle: — Last: White

4. DATE OF DEATH: Month: Feb — Day: 25 — Year: 19 62

5. SEX: Female — 6. COLOR OR RACE: Black — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 22 May 1892

9. AGE (In years last birthday): 70 69 YRS — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country):

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Daniel Queen

14. MOTHER'S MAIDEN NAME: Martha Smowden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: John H. White — Address: Same as No. 2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis
DUE TO (b): Carcinoma of Stomach.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1.a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. City or town — (County) — (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2-17, 19 62 to 2-25, 1962, that (I) (we) last saw the deceased alive on 2-25 19 62, and that death occured at 6.45A M. from the causes and on the date stated above.

22a. SIGNATURE: Jeanne C Bateman M.D

22b. DATE SIGNED: 3/25/62

22c. PHYSICIAN'S NAME (Type): Dr. Jeanne C Bateman M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: 940-25th NW Wash DC

23a. BURIAL, CREMATION, REMOVAL (Specify): — 23b. DATE THEREOF: 3/1/62 — 23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cem. — 23d. LOCATION (City, town or county) (State): Wash. D. C.

24 FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Henry S Washington Inc 4925 Deane Ave, NE

25a. REC'D BY REGISTRAR DATE MAR 1 '62 — 25b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02326

CERTIFICATE OF DEATH

02308

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7'61

1. **PLACE OF DEATH**
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenn Dale (rural)
c. LENGTH OF STAY IN 1b: 23 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Glenn Dale Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: D. C. — b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1330 S. Cap. St.,S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Charles — Middle: W. — Last: White

4. **DATE OF DEATH**: Month: 2 — Day: 3 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐: Separated

8. DATE OF BIRTH: 12/17/04

9. AGE (In years last birthday): 57 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck-driver

10b. KIND OF BUSINESS OR INDUSTRY: Square Deal Truck Co. 1342 S. Cap. St., S.E.

11. BIRTHPLACE (County & State or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Dan Lewis

14. MOTHER'S MAIDEN NAME: Eliza White Hawkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: 579-01-3073

17. INFORMANT: Decedent — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive hemorrhage
DUE TO
(b): Ruptured esophageal varices
DUE TO
(c): Laennec's cirrhosis of the liver

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 2 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary tuberculosis; renal disease with azotemia, etiology undetermined; pulmonary edema

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 —

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1/11/62 to 2/3/62, 1962 that (I) (we) last saw the deceased alive on 2/3/62 19, and that death occured at 3:20 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Moe Weiss M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 2/3/62

22c. PHYSICIAN'S NAME (Type): Moe Weiss, M.D.

22d. ADDRESS: Glenn Dale Hospital Glenn Dale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2-9-62

23c. NAME OF CEMETERY OR CREMATORY: National Harmony Cemetery

23d. LOCATION (City, town or county) (State): Prince George's County, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: John T. Rhines & Co. Robert L. Pleasants

ADDRESS: 3015-10th N.E. D.C.

25a. REC'D BY REGISTRAR DATE: FEB 8 '62

25b. REGISTRAR'S SIGNATURE: [illegible]

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02327 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02309

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: MARYLAND — D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Seat Pleasant
d. STREET ADDRESS: 29 1/2 407 69th. Place
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George — Middle Sidney — Last Windsor

4. DATE OF DEATH: Month February — Day 21, — Year 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 4, 1916

9. AGE (In years last birthday): 45 yrs. — IF UNDER 1 Y: Months ___ Days ___ — IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Car Inspector

10b. KIND OF BUSINESS OR INDUSTRY: Wash. Terminal

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Sidney John Windsor

14. MOTHER'S MAIDEN NAME: May Estelle Windsor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 719-03-1620

17. INFORMANT: Jacob Hezekiah Windsor 517 69th Place — Address: Seat Pleasant, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute congestive heart failure
DUE TO (b): Hypertensive heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒. Inquiry ☒. and in my opinion death resulted from: Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED: 2/22/62

22a. BURIAL, CREMATION REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/26/62

22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln

22d. LOCATION (City, town, or country) (State): Colmar Manor, Maryland

23. FUNERAL DIRECTOR: Francis Gasch's Sons — ADDRESS: Hyattsville, Maryland

24a. REC'D BY REGISTRAR DATE: FEB 26 '62

24b. REGISTRAR'S SIGNATURE: C. Lee L. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02328

CERTIFICATE OF DEATH

02310

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PrinceGeorges General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 19 Morningside
d. STREET ADDRESS: 1 420 Allies Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Preston — Middle: L — Last: Wide

4. DATE OF DEATH: Month: Feb — Day: 20 — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 14 Jan 1905

9. AGE (In years last birthday): 57 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: LIFE INS

11. BIRTHPLACE (County & State, or foreign country): HEVENER OKLAHOMA

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: 350-01-5065

17. INFORMANT: MRS IRENE WISE Address 420 ALLISON ROAD SE WASH 23 DC

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 581.1 Acute Hepatic Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 wks
DUE TO (b): Cancer Liver — 10 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Congestive Failure & A.S.H.D. — 19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (II) (this hospital) attended the deceased from 2/10/1962 to 2/20/1962 that (I) (we) last saw the deceased alive on 2/15/1962 and that death occured at 2.45AM from the causes and on the date stated above.

22a. SIGNATURE: Kelvin L. Minchin M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/20/62

22c. PHYSICIAN'S NAME (Type): Dr. K L Minchin., M.D.

22d. ADDRESS: 7200 Marlboro Pike., S.E. Washington 28 ., D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: FEB 23rd 1962

23c. NAME OF CEMETERY OR CREMATORY: WASH NAT

23d. LOCATION (City, town or county): SUITLAND (State): MD

24 FUNERAL DIRECTOR'S SIGNATURE: [illegible] Chambers Co

ADDRESS: 517-11th ST SE WASH DC

25a. REC'D BY REGISTRAR DATE: FEB 23 '62

25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02329 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02311

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
SM 9/60

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mitchellville
c. LENGTH OF STAY IN 1b: Transient
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1 Mile off Enterprise Road

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: North Caroline
b. COUNTY: Grandville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Creedmoor 70 X-3
d. STREET ADDRESS: Box 64
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ~~KXXX~~ Lounza (Lorenzo) Middle Last Yarbough

4. DATE OF DEATH: Month February Day 21 Year 19 62

5. SEX: Male

6. COLOR OR RACE: Black ~~White~~

7. MARRIED ☒ ~~NEVER MARRIED~~ ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 2, 1916

9. AGE (In years last birthday): 45 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): North Caroline

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Yarbough

14. MOTHER'S MAIDEN NAME: Louise Lawrence

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: Yes ?

17. INFORMANT: Hortense Yarbough — Address: Cedar Cabins Box 272A Jessup Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemorrhage and shock
DUE TO (b): Crushing injuries to the body- multiple- severe
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

9123

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.): Run over by a bull dozer

20c. TIME OF INJURY: Hour 10:45 AM/PM; Month, Day, Year 2/21 19 62

20d. INJURY OCCURRED: While at work ☒ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Constuction area

20f. (City or town) Mitchellville (County) P. G. (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): James I. Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 2/21/62

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 2-25-62

22c. NAME OF CEMETERY OR CREMATORY: POKES CHAPEL CEM.

22d. LOCATION (City, town, or country): CREEDMOR, N.C. (State)

23. FUNERAL DIRECTOR: Charles G. Cooper ADDRESS: CHARLES G. COOPER-512 CARROLLTON AV.

24a. REC'D BY REGISTRAR: DATE FEB 26 '62

24b. REGISTRAR'S SIGNATURE